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Official Report of Debates (Hansard)

Tuesday 24 September 2013

Journal des débats (Hansard)

Mardi 24 septembre 2013

Standing Committee on Social Policy

Committee business

Comité permanent de la politique sociale

Travaux de comité



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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 24 September 2013

Mardi 24 septembre 2013

The committee met at 1606 in committee room 1, following a closed session.

COMMITTEE BUSINESS

The Chair (Mr. Ernie Hardeman): With that, we will then officially call the meeting to order. We have three motions that were tabled, and I will call them in the order that they were tabled. The first one would be Ms. McKenna.

Mrs. Jane McKenna: I move that the social policy committee supports the PC caucus's programming motion, and to proceed with the Local Food Act as programmed in that motion.

The Chair (Mr. Ernie Hardeman): Thank you. Reading that, we would have to rule this motion out of order, as the intent is to follow a document that in fact does not exist. There's no way for the committee to know what that programming motion talks about, so this motion would be out of order.

The next motion that was tabled was from Ms. Jaczek.

Ms. Helena Jaczek: I move that the Clerk, in consultation with the Chair, be authorized to arrange the following with regard to Bill 36, Local Food Act, 2013:

(1) One day of public hearings and one day of clause-by-clause consideration, during its regularly scheduled Tuesday meeting times, commencing Tuesday, October 1, 2013;

(2) Advertisement on the Ontario parliamentary channel, the committee's website and the Canadian NewsWire;

(3) That witnesses be scheduled on a first-come, first-served basis;

(4) That each witness will receive up to five minutes for their presentation, followed by nine minutes for questions from committee members;

(5) That the deadline for written submissions is 3 p.m. on the day of public hearings;

(6) That the research officer provides a summary of the presentations by 12 noon on Thursday, October 3, 2013; and

(7) The deadline for filing amendments with the Clerk of the Committee be 12 noon on Friday, October 4, 2013.

The Chair (Mr. Ernie Hardeman): Ms. Gélinas?

M^{me} France Gélinas: Although it seems all reasonable, I would much prefer that those kinds of conversations happen at subcommittee, where the Chair would

call a meeting of the subcommittee where those, basically, parameters for this bill would be agreed upon and then brought back. We would be voting against this not because what it contains couldn't work, but more because—let's give it due process. We can have a subcommittee meeting really quickly, we can have this conversation at subcommittee and we can bring this back.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek.

Ms. Helena Jaczek: Mr. Chair, obviously the Local Food Act is a priority of our government. I really don't see why we should have a subcommittee meeting. We have all the members here present. If anything, there's an increased richness of discussion when we have all members present. Of course, I will be asking for a recorded vote as well.

The Chair (Mr. Ernie Hardeman): Further comments? Ms. Forster.

Ms. Cindy Forster: Well, in fact, we don't have all the members here. I'm a sub, France is a sub. Our members from social policy aren't even at this meeting, because they're tied up in other things at this point. I think it really is circumventing the whole premise of having a subcommittee: so that people can get together to actually enter into those discussions about the things that are contained in this particular motion. I don't think anybody's trying to hold up anything here. What we're attempting to do is follow due process.

The Chair (Mr. Ernie Hardeman): Further comments? If not, before I call the vote, there is a point I just wanted to make for the information of the committee, not to take a position on it. Being on a Tuesday meeting, though the resolution says "One day of hearings and one day of clause-by-clause," that's two hours of hearings and two hours of clause-by-clause, because on Mondays we have a longer day, but on Tuesdays it's only a two-hour meeting.

The other thing that I did want to point out is that this motion passed by this committee is not the same as a programming motion passed by the Legislature coming here. This resolution is as good as the length of time between this vote and the next vote that could be taken on exactly the same issue. The committee does have the power to change what's in this one.

With that, further comment?

Ms. Helena Jaczek: Thank you, Chair. Notwithstanding your clarifications and so on, we wish to proceed

with this in a timely fashion and make the statement right here, today, with this vote.

The Chair (Mr. Ernie Hardeman): Any further—yes, Ms. Forster.

Ms. Cindy Forster: Before the vote, then, I'd like to call for a recess.

The Chair (Mr. Ernie Hardeman): A recess has been asked for—

Ms. Cindy Forster: Ten minutes.

The Chair (Mr. Ernie Hardeman): The committee will recess for 20 minutes.

The Clerk of the Committee (Mr. William Short): Ten.

The Chair (Mr. Ernie Hardeman): Ten minutes. Okay. I just thought you'd want the whole time.

The Clerk of the Committee (Mr. William Short): It's 4:12—

The Chair (Mr. Ernie Hardeman): We will reconvene at 4:12—

The Clerk of the Committee (Mr. William Short): —4:22.

The Chair (Mr. Ernie Hardeman): —4:22. Oh, 4:12 is what it is now.

The committee recessed from 1612 to 1622.

The Chair (Mr. Ernie Hardeman): We call the meeting back to order, and we'll go back to the third party. Comment?

Ms. Cindy Forster: Yes. I still think that we're circumventing the subcommittee role by not holding a subcommittee meeting. We're not attempting to hold up this particular bill. We've said in the House that we're supportive of it, although we'll probably like to make a few amendments to it, and we don't believe that we should be dealing with this here and today.

The Chair (Mr. Ernie Hardeman): Further debate? If not, we'll call the question. It's a recorded vote.

Ayes

Balkissoon, Berardinetti, Elliott, Jaczek, McKenna, Wong.

Nays

Forster, Gélinas.

The Chair (Mr. Ernie Hardeman): I declare the motion carried.

The third motion was tabled by the third party. Ms. Forster.

Ms. Cindy Forster: I move that, pursuant to standing order 111(a), the Standing Committee on Social Policy study and report on all matters related to the mandate, management, organization and operation of Ontario's system of local health integration networks (LHINs). The study shall include but not be limited to:

(a) Consider the best models of health care service delivery, governance and health care by looking at best practices in both Canada and abroad;

(b) Review decision-making at Ontario's LHINs and whether local representation, accountability and transparency are incorporated into the process and, if not, how and where these can be better achieved;

(c) Invite input from expert witnesses, including LHIN board members and employees, board members and employees from other health service organizations and health care policy experts in all health sectors;

(d) Consider the recommendations of the 2012 Drummond report, which identified potential savings of up to \$1 billion in Ontario's LHINs and the broader health care system.

And that committee meetings on this study shall begin during the regularly scheduled hours of the Standing Committee on Social Policy on Monday, September 30, 2013.

The Chair (Mr. Ernie Hardeman): Very good. Thank you very much. With that, comments from the third party.

Ms. Cindy Forster: Certainly our party, the NDP caucus, wants to get this LHIN review done. It has been a long time coming. It's actually, I think, about three and a half years in arrears of the government's own legislation, which was, I believe, March 28, 2010. We have asked numerous questions in the House over the past two years about when the LHINs were actually going to be reviewed by the health minister and during debates in the House. In light of the fact that there is constant restructuring happening in hospitals, long-term care and the community, I think it's imperative that we have this review done now, before there is more dismantling occurring, before more smaller and rural local hospitals close. We believe that it's actually time to do that review now.

The Chair (Mr. Ernie Hardeman): Further debate?

Ms. Helena Jaczek: We are, of course, eager to also review the LHINs. However, I do notice that we have an amendment here, I believe, which we would be interested in hearing a little bit more about.

Mrs. Jane McKenna: I have an amendment that the following be deleted: "on Monday, September 30, 2013" and replaced with "commencing after Bill 36, Local Food Act and the study relating to the oversight, monitoring and regulation of non-accredited pharmaceutical companies are both reported to the House."

The Chair (Mr. Ernie Hardeman): Okay, you've heard the amendment. Discussion on the amendment?

Ms. Helena Jaczek: Certainly we on the government side find the amendment a useful one. We think that we should complete what we've started in an orderly fashion, so we'll certainly be voting in favour of the amendment.

The Chair (Mr. Ernie Hardeman): Further discussion?

M^{me} France Gélinas: We're trying to make absolutely sure that we have the right amendment. The right amendment—

The Chair (Mr. Ernie Hardeman): The amendment is, if you look at the bottom, that the following be deleted: “on Monday, September 30, 2013.” That’s the bottom line in the original motion.

M^{me} France Gélinas: Yes, and replaced—

The Chair (Mr. Ernie Hardeman): And replaced with “commencing after Bill 36, Local Food Act and the study relating to the oversight, monitoring and regulation of non-accredited pharmaceutical companies are both reported to the House.”

It takes the deadline or the timing of this one starting to when the end of the work that’s before the committee is completed.

M^{me} France Gélinas: Although I reserve the right to ask for a recess, because I easily get confused, what are we going to do on the 30th, given that this doesn’t start till the 1st?

The Chair (Mr. Ernie Hardeman): That isn’t part of this resolution and it isn’t part of the process. The committee would go on with its regular work on the pharmaceutical issue and the report writing. That would carry on until we got new direction from the committee as to what we wanted to do apart from that.

M^{me} France Gélinas: I was under the impression that our next meeting to deal with the pharmaceutical issue was going to be when Health Canada was available and Health Canada is not going to be available till—that’s where you pipe in, Will, to give me the date.

The Clerk of the Committee (Mr. William Short): Tuesday, October 8.

The Chair (Mr. Ernie Hardeman): This resolution and the amendment, in fact, do not deal with that. We would be carrying on the regular business; if they’re not yet available, we would be working on report writing while we were waiting for the Health Canada delegation to be able to be here. That would keep going till whatever time any of these resolutions kicked in, remembering that the committee has the power to change these resolutions at will, the same way we created them today. As you move forward, you can change those.

The approach right now is that what is before the committee is the pharmaceutical one, and what this is doing is trying to put our work in the future in. The amendment would ask that—

M^{me} France Gélinas: We will need five minutes, now that I am straighter as to what’s going to happen when.

The Chair (Mr. Ernie Hardeman): Okay.

Ms. Cindy Forster: Before we actually recess, just so that I’m clear, what this amendment is suggesting is that the food act bill is going; that we continue to finish off the pharmaceutical issues, even if we don’t have witnesses to come forward; and that the LHINs review would immediately follow that. Is that the suggestion?

Ms. Helena Jaczek: Yes, and we’ll be less confused if we do it that way.

The Chair (Mr. Ernie Hardeman): Where we stand now, the previous motion put the food act into the mix for processing as we go forward.

M^{me} France Gélinas: We will ask for a six-minute recess.

The Chair (Mr. Ernie Hardeman): Six minutes. Adjourned for six minutes.

The committee recessed from 1630 to 1634.

The Chair (Mr. Ernie Hardeman): We’ll come back to order; back to the third party.

M^{me} France Gélinas: I want to make sure that I understand. When we say “both are reported to the House,” there are delays there. Between the time we finish and the translation is done and then it goes to the House, there are lapses. I have no problem with the food act, which has been scheduled. We’re almost done with hearing people on the diluted chemo drugs; I’m hoping that we will be able to have a report. Does that mean that as soon as this report is done, we start on the LHINs, or does it mean that I have to wait until the translation is done and the this and the that?

The Chair (Mr. Ernie Hardeman): The amendment is clear that it’s reported to the House, not received by the House. The day that we call the vote, “Shall the Chair give the report to the House”—that’s when we can start something else, the minute it leaves this committee.

M^{me} France Gélinas: And you will ask that question before we send it to translation?

The Chair (Mr. Ernie Hardeman): Yes. That’s the day that the report is complete here—“Shall the title of it carry?” and all this, whatever. The last vote on it is to report it to the House. That’s before it goes to translation, and then it’s translated after it’s reported.

M^{me} France Gélinas: So am I right in saying that on the 30th we’ll do reporting writing on chemo, then we deal with the Local Food Act on the 1st and then the clause-by-clause? Then we continue to work on the chemo, and the day that the chemo is done, we go to the LHINs. Am I right?

The Chair (Mr. Ernie Hardeman): Yes, but I think we should—I don’t want to leave the assumption that on the 30th, when we write the report for the chemo, that in fact the report will be written on the 30th. How long it takes us to write the report is how long it will be before we’re on to something else. According to this motion, when those two bills are moved out of this committee, we go directly to the LHINs.

Any further debate on it? Yes, Ms. Forster?

Ms. Cindy Forster: So just to be clear, there will be no other business before this committee prior to the LHINs?

Mr. Bas Balkissoon: Unless you’re ordered by the House.

The Chair (Mr. Ernie Hardeman): I would point out, as was so ably said by my assistant, unless it’s ordered by the House or unless this committee decides, with a majority vote, to do something else. There is nothing binding about what we’re doing here on the committee.

Earlier there was some discussion about the subcommittee. This is what we’re doing. We’re just superseding subcommittee in setting committee business. So it’s not

binding, and you can change that at any point in time. But the way it's written here, those two items would be finished and this amendment says then we would look at the LHINs.

M^{me} France Gélinas: So the only way to change this would be an order from the House?

The Chair (Mr. Ernie Hardeman): No. It can be changed right at this committee.

M^{me} France Gélinas: If we all agree?

The Chair (Mr. Ernie Hardeman): No, not all agree. A majority vote.

M^{me} France Gélinas: If the majority votes—

The Chair (Mr. Ernie Hardeman): Yes.

M^{me} France Gélinas: Okay.

The Chair (Mr. Ernie Hardeman): And incidentally, that's as tight as this committee can set this type of business. There's no way we can make this more binding than it is, as a committee.

M^{me} France Gélinas: Okay, but it would be as binding as the one we just passed on the Local Food Act—

The Chair (Mr. Ernie Hardeman): Exactly.

M^{me} France Gélinas: It would be as binding as anything else.

The Chair (Mr. Ernie Hardeman): Exactly the same.

M^{me} France Gélinas: I'm starting to see the light.

The Chair (Mr. Ernie Hardeman): Any further comments or questions?

We'll call the question on the amendment. All those in favour of the amendment? Opposed? The motion is carried.

Now, any debate on the motion, as amended?

Ms. Cindy Forster: I'll just make a few comments.

The Chair (Mr. Ernie Hardeman): Yes, Ms. Forster?

Ms. Cindy Forster: I just think that this is a really important issue for us to be dealing with in light of all of the restructuring and transformation. There are so many buzzwords that have been used in health care, certainly over the last 20 years, and the changes are happening very rapidly as we even heard in the House this morning, right? So I think it's imperative that this be the next on the list to be reviewed, and I hope, from our perspective, that we get the support to make sure that that happens.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek?

Ms. Helena Jaczek: We concur.

The Chair (Mr. Ernie Hardeman): It took a long time to get to hear that. But anyway, any further debate on the motion, as amended? If not, we'll call the question.

All those in favour? Opposed, if any? The motion is carried.

That concludes the issue of motions. We will now go back into an in camera session and start the report writing.

The committee continued in closed session at 1639.

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Mr. Ernie Hardeman (Oxford PC)

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Mrs. Christine Elliott (Whitby–Oshawa PC)

Ms. Cindy Forster (Welland ND)

M^{me} France Gélinas (Nickel Belt ND)

Ms. Soo Wong (Scarborough–Agincourt L)

Also taking part / Autres participants et participantes

Mr. Jeff Yurek (Elgin–Middlesex–London PC)

Clerk / Greffier

Mr. William Short

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 30 September 2013

Lundi 30 septembre 2013

The committee met at 1402 in committee room 1.

COMMITTEE BUSINESS

The Chair (Mr. Ernie Hardeman): I call the meeting of the committee on social policy for Monday, September 30, to order. We are here to do a study relating to the oversight, monitoring and regulation of non-accredited pharmaceutical companies.

Before we do that, I believe the meeting was scheduled to be an in camera meeting on report writing, but there are a couple of things that we needed to clean up. One was the resolutions that the committee put forward and the suggestions of how they should be written at the last meeting, and we'd like to have those presented.

The second thing—and I just bring this forward and ask the committee to consider it—relates to tomorrow's meeting for the Local Food Act, which was passed in a resolution at the last meeting. We're going to run into a bit of a problem as it's part of the programming motion that's in the House now. If the programming motion gets voted on today, then in fact our meeting tomorrow is out of order because it would be overridden by the first meeting of that programming motion. It says that the meeting will be next Tuesday.

The Clerk of the Committee (Mr. William Short): The following Tuesday.

The Chair (Mr. Ernie Hardeman): The first Tuesday following the week in which the programming motion was passed. If it doesn't pass today, it means that it will be debated tomorrow and we cannot discuss that in the committee while it's being debated in the Legislature. The problem with this, of course, arises as we have delegations coming in, so it will be a public presentation. In order to give them time to not come, we would need a motion from the committee today to cancel tomorrow's meeting and wait till next week. Regardless of whether the motion passes, next Tuesday would still be the day that this committee would hold it without the programming motion, and it's also the day that would be the right one for the programming motion. So it would solve all the problems if we don't hold the meeting tomorrow.

With that, if you have any discussion on that. Yes?

M^{me} France Gélinas: No, I didn't have any discussion on that. My head is still spinning a little bit as to what we're doing and not doing. Do we have to decide right now or could we decide after we finish our work for today?

The Chair (Mr. Ernie Hardeman): We could decide that at any time. The sooner we decide it, the more time they will have to let people know who were scheduled to be here tomorrow not to come tomorrow. If we wait till late afternoon, some of the people won't find out. There are some appointments scheduled for tomorrow, but—

M^{me} France Gélinas: Because tomorrow we were supposed to go to committee hearings on the good food bill—

The Chair (Mr. Ernie Hardeman): The Local Food Act, yes.

M^{me} France Gélinas: The Local Food Act, sorry. Tell me again why we can't do that?

The Chair (Mr. Ernie Hardeman): Well, first of all, the Local Food Act is in the programming motion that's being debated in the Legislature as we speak. If the motion that's before the House right now passes, the motion we passed last week is irrelevant because the one upstairs overrides the motion of the committee. Now, if it doesn't pass today—because it's a motion that can continue debate. So if it's still being debated tomorrow, then we can't hold the meeting on the same topic in committee that the House is debating upstairs. So, in both cases, we can't have that hearing tomorrow.

Rather than waiting until tomorrow and having the committee and having the people sitting here ready to present and then say, "I'm sorry, but you can't present today because of the procedural thing," I'm suggesting that we have a motion to just cancel tomorrow's meeting so that the Clerk can let them now that it won't be till next Tuesday that they can come. Either way, next Tuesday we can have a meeting on it. If the motion passes, that's the day the motion suggests we're supposed to start the hearings; if not, we can then just have the regular business scheduled that day of meeting.

Ms. Helena Jaczek: It seems pretty clear: We cannot have any deputations tomorrow—

The Chair (Mr. Ernie Hardeman): That's why I didn't ask the Clerk to prepare any formal—it's just a motion to—

Ms. Helena Jaczek: I will move that we cancel tomorrow's committee hearing.

The Chair (Mr. Ernie Hardeman): Okay. Any further questions or debate on it?

Interjection.

The Chair (Mr. Ernie Hardeman): It will have no impact on whether the motion passes or doesn't.

M^{me} France G  linas: No, but neither one of us followed those procedures too closely; we may need a five-minute recess. Or can we deal with this after?

The Chair (Mr. Ernie Hardeman): You want a five-minute recess before you call the vote on this?

M^{me} France G  linas: Yes.

The Chair (Mr. Ernie Hardeman): You can ask for a 20-minute recess or five minutes, whatever you like. Okay?

Ms. Helena Jaczek: Let's do it now, because—

Interjections.

The Chair (Mr. Ernie Hardeman): We will recess the meeting until you get back with the comment.

The committee recessed from 1407 to 1414.

The Chair (Mr. Ernie Hardeman): I see that everyone has returned to the committee, so we'll call the committee back to order.

Interjections.

The Chair (Mr. Ernie Hardeman): If we could just hold it down over there so we can hear from this long-awaited report on—

M^{me} France G  linas: Well, no. I just find it so disappointing that in order—if nothing was happening in the House, we would deal with the good food act tomorrow. It would go to clause-by-clause next Tuesday, and we would be done with it. But this motion to hurry things up actually slows things down. Those are some of the mysteries of this place. I'm not happy with it, but I guess have no say about it.

The Chair (Mr. Ernie Hardeman): I would point out, beyond what I said earlier, that even if we have the day of hearings and then that motion passes, the day we had is null and void. We have to do two days anyway, so really, this one isn't speeding it up and it isn't slowing it down. All we're looking to do is to cancel this one because it's going to be null and void before we're finished.

Any further discussion? If not, all those in favour of cancelling the day of hearings tomorrow? Opposed? The motion is carried. The Clerk will be able to advise the people who were going to present tomorrow not to show up. Some of them do have to come from a fair distance, so we want to make sure that when they get here, they can present.

The next item of business, of course, is the motions that were sent out that we instructed the Clerk to get ready for us. They're numbered 1, 2 and 3. If someone would make a motion on number 1, we can have discussions and make changes to it if you see fit.

Ms. G  linas will move motion number 1.

M^{me} France G  linas: I move that the Standing Committee on Social Policy request Medbuy Corp. to provide the committee with a complete list of all Medbuy employees, their job titles and compensation, (salaries, bonuses, benefits and/or stipends) for the last two fiscal years.

Interjections.

M^{me} France G  linas: It sounds pretty weird if I move it and amend it.

The Chair (Mr. Ernie Hardeman): Okay, then we'll need to, if we could, get the amendments from the motion that the rest of the committee has.

M^{me} France G  linas: Do you want me to tell you the difference between the two?

The Chair (Mr. Ernie Hardeman): The Clerk suggested that we should make copies of the one you read so that everyone can see it before they have to vote on it.

M^{me} France G  linas: Okay.

The Chair (Mr. Ernie Hardeman): Okay, we're going to have to recess for another five minutes, or maybe 10, depending on when the Clerk gets back with the copies.

The committee recessed from 1417 to 1423.

The Chair (Mr. Ernie Hardeman): I will call the committee back to order. I would just point out to the committee that since all three of the motions that you had were in fact all slight amendments to the original motions, the original motions were not put forward at all, so we will call these the original motions. So if anybody wants to make amendments, it would be amendments to these motions. But nothing more than just putting the motion is necessary for these.

With that, Ms. G  linas—

M^{me} France G  linas: I realize that I moved it, but I—

The Chair (Mr. Ernie Hardeman): I would ask you just to read it again.

M^{me} France G  linas: I move that the Standing Committee on Social Policy request Medbuy Corp. to provide the committee with a complete list of all Medbuy employees, their job title and compensation (salaries, bonuses, benefits and/or stipends) for the last two fiscal years.

But as I'm reading it, I'm thinking maybe "employees" could lead to interpretation, so I would say "employees, management and directors."

The Chair (Mr. Ernie Hardeman): "Employees, management"—

M^{me} France G  linas: —"and directors".

The Chair (Mr. Ernie Hardeman): Okay. You've heard the amendment on the motion—yes?

Mr. Bas Balkissoon: Mr. Chair, just one question of the mover: When you put "(salaries, bonuses, benefits and/or stipends)", are we running the risk that Medbuy could combine all of that and put it as one figure, and we'll never figure out what it is?

M^{me} France G  linas: "And stipends"? Take away the "or"?

Mr. Bas Balkissoon: No, no, it's to remove the brackets: "compensation," with details of each. Because if you put it in brackets, they could interpret it that you want it as one big number.

M^{me} France G  linas: Okay.

Ms. Cindy Forster: Detailed compensation of each—of salaries, bonuses, benefits and stipends.

Mr. Bas Balkissoon: Accept that as a friendly—

The Chair (Mr. Ernie Hardeman): Yes, it's a friendly amendment. I don't think there's any problem.

My question is whether you're going to achieve what you want. I think it's important to recognize that the word "stipends" is a replacement for all others. When you get a stipend, it's just an amount of money. It has nothing to do with wages, nothing to do with benefits—it has nothing to do with anything. A stipend could be somebody on the board who is not considered an employee; they don't get paid, but they do get a stipend for being there.

Ms. Helena Jaczek: But we want to add management and members of the board of directors, correct?

M^{me} France Gélinas: Yes, so that if, like Ornge, they get a \$2,000 stipend, I wouldn't mind knowing.

The Chair (Mr. Ernie Hardeman): Okay. No, that's fine. I just wanted to make sure we didn't overlook the fact.

Yes, Ms. Elliott.

Mrs. Christine Elliott: Could we maybe just break that down and say "and a breakdown of their compensation"?

M^{me} France Gélinas: "And a detailed breakdown of their compensation".

Mrs. Christine Elliott: Does that make sense?

M^{me} France Gélinas: Yes, it does.

The Chair (Mr. Ernie Hardeman): Did you want to then, if you could, read it again with those changes?

M^{me} France Gélinas: I move that the Standing Committee on Social Policy request Medbuy Corp. to provide the committee with a complete list of all Medbuy employees, management and directors, their job title and a detailed breakdown of their compensation, including salaries, bonuses, benefits and/or stipends, for the last two financial years.

The Chair (Mr. Ernie Hardeman): Any further debate on the motion? I have a question that you might want to consider. When you make a list of all the employees by name, is that beyond the freedom-of-information act, that we're not entitled to that information?

Ms. Helena Jaczek: Well, why wouldn't we ask and see what happens?

The Chair (Mr. Ernie Hardeman): No, I'm just saying it might have to be done again. If you could just get the positions as opposed to people's names, then it would be public information.

M^{me} France Gélinas: Well, if they gave to us names and positions, we can then choose to make it public with positions, taking the names off. But if the same person has the position of VP, assistant VP and deputy VP, I'd like to know that the same person has three jobs of \$100,000 each.

The Chair (Mr. Ernie Hardeman): Okay. Any further discussion? If not, all those in favour of the motion? Opposed, if any? That one is carried.

Motion 2, Ms. Gélinas.

M^{me} France Gélinas: I move that the Standing Committee on Social Policy request Medbuy Corp. to provide the committee with detailed financial statements of the last two fiscal years. The statements must clearly show the amount transferred back to the member hospitals.

The Chair (Mr. Ernie Hardeman): You've heard this motion. Any discussion on this motion? Yes, Ms. Forster.

Ms. Cindy Forster: I think, just for clarity, if we said "to each of the member hospitals" as opposed to them giving us a lump sum of what they paid back to, perhaps, all four together—to show the amount transferred back to each of the member hospitals."

1430

The Chair (Mr. Ernie Hardeman): I don't have any problem with it. I believe it's covered with "member" and "hospitals" with an "s."

M^{me} France Gélinas: Just in case.

The Chair (Mr. Ernie Hardeman): But "each" will make it clearer.

Any other comments? If not, all those in favour of this resolution? Opposed, if any? The motion's carried.

Number 3.

M^{me} France Gélinas: I move that the Standing Committee on Social Policy request Peterborough Regional Health Centre, Lakeridge Health, Windsor Regional Hospital and London Health Sciences provide the committee with a detailed financial statement for the last two fiscal years highlighting the rebates that the hospital received from Medbuy Corp.

The Chair (Mr. Ernie Hardeman): Discussion? In the resolution, when you say "provide the committee with a detailed financial statement for the last two fiscal years," are we expecting the total hospital budget or just that portion that refers to buying medication? I just have a fear that we're talking—

Mr. Bas Balkissoon: Well, we're going to try and follow the money, so if it didn't go back to drug purchases, where did it go?

The Chair (Mr. Ernie Hardeman): No, no, I'm just saying that I expect the financial budget of the hospital would be a large document.

Mr. Bas Balkissoon: But that's the only way we'll follow where they put the money.

The Chair (Mr. Ernie Hardeman): Okay. As long as you understand that that's what we're doing.

Ms. Cindy Forster: And I think if you added the word "including" after "2012-13" where it's struck out, so it would be "with a detailed financial statement for the last two fiscal years, including highlighting the rebates that the hospital received from Medbuy Corp." It makes it clear you're looking for the financial statement plus the rebates.

The Chair (Mr. Ernie Hardeman): Well, I think when you say "a detailed financial statement," it says that you want the whole statement and then they must highlight that area that we're talking about. So I don't think we need to add any more than that. Okay?

Any further discussion? If not, all those in favour of the motion? Opposed, if any? The motion's carried.

That concludes the motions that we're asking to be dealt with.

Ms. Helena Jaczek: Mr. Chair, before we go into closed session, I would like to bring to everyone's atten-

tion a letter that I have to yourself from the Minister of Health and Long-Term Care—I think everyone has a copy—dated March 18, 2013.

The Chair (Mr. Ernie Hardeman): Everyone has a copy? It's been distributed to the committee.

Ms. Helena Jaczek: On looking at the motion that we passed last week in relation to the LHIN review, and looking at this letter, it appears that we need some further clarification of the terms of reference to include a review of the Local Health System Integration Act, the piece of legislation. In the motion that we passed, there's no reference to a review of the act itself. So I just wondered how we should proceed. I think there are some procedural issues here.

The Chair (Mr. Ernie Hardeman): Okay. With that, the Clerk would like to explain the reasons.

The Clerk of the Committee (Mr. William Short): The reason the NDP motion did not include that is because the motion would have been out of order. The only way that the committee can look at the Local Health System Integration Act is by motion from the House, similar to if a committee was to look at a piece of legislation, that piece of legislation needs to be referred to that standing committee. In this case, I understand that within four years there was to be a review, but it didn't state that the Standing Committee on Social Policy was to do that review; it was that a standing committee of the Legislative Assembly. So the House would have to refer this.

We did bring this up to the House leaders that last time this came around, that there would need to be a motion in the House for the committee to be able to look at that.

Ms. Helena Jaczek: So the minister needs to—who makes that motion to the House?

The Clerk of the Committee (Mr. William Short): The government House leader.

Ms. Helena Jaczek: The government House leader. So our government House leader needs to do that?

The Chair (Mr. Ernie Hardeman): Yes, the Minister of Health would ask the government House to put forward a motion to do that.

Ms. Helena Jaczek: Because I think the intention is to look at the legislation as well, so we should include that.

The Chair (Mr. Ernie Hardeman): Yes.

Ms. Helena Jaczek: Okay. Thank you. We'll take that back, then. I just wanted to clarify that.

The Chair (Mr. Ernie Hardeman): I think the suggestion would be that the government House leader, along with the House leaders, would decide to put it forward without debate, and unanimous consent would then be able to move it forward. Okay?

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you.

With that, we'll go into closed session. Do we have a motion to go into closed session? Ms. McKenna? Ms. Elliott, okay.

The committee continued in closed session at 1435.

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Ms. Cindy Forster (Welland ND)

M^{me} France Gélinas (Nickel Belt ND)

Clerk / Greffier

Mr. William Short

Staff / Personnel

Ms. Elaine Campbell, research officer,
Research Services



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Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40^e législature

Official Report of Debates (Hansard)

Monday 7 October 2013

Journal des débats (Hansard)

Lundi 7 octobre 2013

Standing Committee on Social Policy

Subcommittee report

Comité permanent de la politique sociale

Rapport du sous-comité



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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 7 October 2013

Lundi 7 octobre 2013

The committee met at 1401 in committee room 1.

SUBCOMMITTEE REPORT

The Chair (Mr. Ernie Hardeman): I call this meeting of the Standing Committee on Social Policy to order. According to the agenda, we are meeting today to discuss chemotherapy drugs. Just prior to going into closed session for the debate, we have a motion from the subcommittee report to deal with the public hearings starting tomorrow. We'd like the whole committee to consider that subcommittee report before we go into closed session so staff can get on with arranging tomorrow's meeting. We have a motion. Mrs. Elliott?

Mrs. Christine Elliott: Yes, Chair. I'd be happy to make the motion.

Your subcommittee met on Monday, October 7, 2013, to consider the method of proceeding on Bill 36, An Act to enact the Local Food Act, 2013, and recommends the following:

(1) That, in addition to the motion carried in full committee regarding Bill 36 on Monday, September 23, 2013, the subcommittee recommends the following:

(2) That the committee Clerk, in consultation with the Chair, repost an advertisement regarding Bill 36 on the

Ontario parliamentary channel, Canada NewsWire and the committee's website.

(3) That the deadline for written submissions be 5 p.m. on Tuesday, October 22, 2013.

(4) That the research officer provide a summary of the presentations by Thursday, October 24, 2013.

(5) That the committee Clerk, in consultation with the Chair, be authorized prior to the adoption of the report of the subcommittee to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Ernie Hardeman): I would just point out to the committee that it's not as broad a subcommittee report as we normally have because it is according to the programming motion that was passed in the House. All other aspects of the hearings are in the programming motion, so it's just the housekeeping, the procedural things, that we need to do in order to move this forward. With that, any comments or questions?

If not, all those in favour of the report? Opposed? The motion is carried.

That's the only thing that we need to do. A motion to go in camera for discussion of the chemotherapy? Mrs. Elliott? Okay, we're in camera.

The committee continued in closed session at 1404.

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STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 8 October 2013

Mardi 8 octobre 2013

*The committee met at 1603 in committee room 1.*LOCAL FOOD ACT, 2013
LOI DE 2013 SUR
LES ALIMENTS LOCAUX

Consideration of the following bill:

Bill 36, An Act to enact the Local Food Act, 2013 /
Projet de loi 36, Loi édictant la Loi de 2013 sur les
aliments locaux.

The Vice-Chair (Mr. Ted Chudleigh): We'll call the meeting to order. The Standing Committee on Social Policy is here to go into hearings on Bill 36, An Act to enact the Local Food Act, 2013.

HOLLAND MARSH
GROWERS' ASSOCIATION

The Vice-Chair (Mr. Ted Chudleigh): Our first depute is the Holland Marsh Growers' Association, represented by Jamie Reaume, executive director. Thank you very much for joining us today. If you would identify yourself for the purpose of Hansard. You have five minutes to make a presentation, and it will be followed by three minutes of questioning from each of the three parties. If you'd like to proceed.

Mr. Jamie Reaume: Thank you, Mr. Chair. Jamie Reaume, executive director, Holland Marsh—

The Vice-Chair (Mr. Ted Chudleigh): One other thing: I will give you a signal when you have a minute left.

Mr. Jamie Reaume: Thank you. Jamie Reaume, Holland Marsh Growers' Association. I'm the executive director. I'm also the chair of the Ontario Food Terminal Board, so I wear a joint hat when it comes to the Local Food Act.

My comments will be relatively brief; I'll probably just use the five minutes. Obviously, we speak in favour of the act in regard to what's there, but we do have a preference for some things we would like to see.

Primarily, we do agree with the Bob Bailey bill about taxation, simply because that is the right thing to do for farmers. One of my farmers and our organization were approached to do a donation for the Ontario public service this week. We've donated 2,000 pounds of carrots and 2,000 pounds of onions that will be at the Daily Bread Food Bank. That was through Hillside Gardens,

Ron Gleason. That's about \$1,500 worth of product from their end, and that's what our guys do all the time. We are very generous people in the Holland Marsh; we are always giving. The numbers are astronomical when it comes to the fresh produce side, and this is merely a way to acknowledge that we actually do good work for the communities. That's what these guys are based around: being good stewards of both the land and the communities that they service.

Second to that, we do serve as the Holland Marsh, meaning that we are outside of the GTA by approximately 50 kilometres. In short, we are Ontario's soup and salad bowl and the Toronto area's backyard garden. We grow 67 different crops and a multitude of varieties. You feed your cities because of us. Therefore, we have a big picture in what we'd like to see. But this act itself is just a start. This act is merely a cornerstone. We want to see it passed, because then the dialogue and the debate becomes around what we do to make things better. Bits and pieces are not going to help. Mere amendments won't just add to it. We need to be able to look at this as a one-window opportunity of what we do in farming and food.

It's the reason why we also think that the week should be moved, not because we don't celebrate farming and food, but because we think that food is a different item than the farming aspect is. We'd like to see the week moved to June. We've stressed that before. The reason for that is that Queen's Park holds its farmers' market on its front yard with 20 to 30 different organizations that talk about the upcoming harvest, that talk about the availability of food, that provide an educational component to this industry that we all want to see do better.

That's why we step up and say that this is really an educational piece. This local food bill can become convoluted and lose the teeth that are required that would come under other acts. If you want to play on the distribution side and food hubs, then open up the Ontario Food Terminal Act. There's a specific clause on that. If you want to talk about snacks, if you want to talk about meals, then go to the Ministry of Children and Youth Services and discuss how to make that better. If you want to talk about legislative purposes, there are committees for that.

This is a social agenda committee, primarily. If I read the committee correctly, you're here for the fairness of all Ontario. Therefore—

The Vice-Chair (Mr. Ted Chudleigh): One minute.

Mr. Jamie Reaume: I've got my one minute? Beautiful.

Therefore, in essence, what we're saying is that this is a social contact, this is a social act, this is a social bill that is geared to the consumer at the end. We applaud that. We thank you. But you could no more legislate local food to be eaten by your constituents than you can collect every tax dollar that's available in this province. We think this is a good start. We want to see it progress more, but we see this as a cornerstone piece to what we would call an Ontario food strategy, a much larger piece that fits the needs of all the citizens of Ontario.

Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Jamie; it was very good.

We'll start with three minutes of questioning from the official opposition. Mr. Hardeman.

Mr. Ernie Hardeman: Thank you very much, Mr. Chairman, and thank you very much, Jamie, for your presentation.

You mentioned something about the food terminal and what we could do to make the system better. Could you just elaborate a little bit on it, mandating only Ontario food in your—I presume that's just in the farmers' market or into the open market rather than in the whole terminal?

Mr. Jamie Reaume: Yes and no. My mandate is pretty crystal clear, and it's from all the parties, and that is that we need to improve local food inside the terminal. We've started the process. Right now, we have Ontario farmers that serve Ontario products, but on what we call the horseshoe or that U that we talk about, we also have Ontario farmers that are not only servicing Ontario products and farmers in bringing in food, but they also get involved in the 365/7/24 that has become commonplace.

But, in answer to your question, we are seeing an increase in local food. We're up to about 23% or 24% as of this past year. We just set a record in that we moved more than a million tons of food through the terminal, which has never happened in its mandate, and what we'd like to see is an increase of at least 2% to 3% every year of more local product going through. That's realistic for the amount of exportation that—

1610

Mr. Ernie Hardeman: The other thing I'd like to ask about: You mentioned the tax credit for farmers donating to food banks. I've heard some concerns expressed about how much bookkeeping that would take if you put that in place, and where the burden would be. How do you keep track of a tax credit for something you take out of the field directly to a food bank? Could you give some advice as to how we would deal with it to make sure that we had honest accounting, to make sure that the amount of food and the amount of credit going are appropriate?

Mr. Jamie Reaume: Well, in answer to your question, my guys have now become prolific bookkeepers, despite the fact that they really don't want to be. They're involved in traceability. They're involved, as many of the

farmers are, in accountability for each of the fields that they do.

It's a relatively simple process once you're donating, because, really, you're only donating 100 to 200 pounds a week, and what happens is that you are able to build upon that. My guys do this all the time. Dominion, Bradford and District co-op—they donate a skid a week; at Thanksgiving particularly, then they'll do 10 skids. Five years ago, when we started, we donated a tractor-trailer load, 24 straight skids—2,000 pounds each, 48,000 pounds—down to the city of Toronto.

We can keep account of this. I think that the problem with it is going to be twofold for that, and I say this in sincerity: First, there is going to be a federal implication to this; and second, there needs to be an easier delivery mechanism around the tax credit itself. But is it doable? Absolutely. I'm afraid that my guys aren't out there to try and kind of rob Peter to pay Paul. They are actually doing this out of the generosity of their hearts to start with. They are not about to scam the system.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Third party?

Mr. John Vanthof: Thanks, Jamie, for coming. I really appreciate it. I drive through the Holland Marsh every week on my way to work, so I appreciate the Holland Marsh, and I appreciate all of your comments.

Regarding the tax credit, I think you're an example of where this would fit perfectly; I really think so. But I have a couple of questions about other areas, and I would like to hear your expertise.

As a dairy farmer, you can donate milk. A farmer donates some milk, and the processor donates the processing. Because a lot of products, maybe not fresh vegetables, but a lot of products, require processing. We're having problems about how to quantify a dollar amount for the raw product for a donation, yet there's no donation for the processing. What would you think about the idea of including processing as well?

Mr. Jamie Reaume: Am I being honest about this?

Mr. John Vanthof: I would appreciate it.

Mr. Jamie Reaume: All of my guys deal with processing of some form or another. If that was not the case, you'd be getting dirty carrots and dirty lettuce, so it is processed to that level. In the Marsh, particularly, we're an example of where farmers grow specifically for the processing side, meaning they grow for a Hillside or a Carron Farms.

It's the same opportunity for the processors of dairy. I believe that anybody involved in the system, meaning anybody involved in that farming side, should be eligible for it, as long as there is an understanding between the farmer—the giver of, say, a raw product. And that includes pigs as well; you can't just drop a pig off—

Interjection.

Mr. Jamie Reaume: Well, I'd like to see it, but it doesn't happen. You can't drop a cow. There's processing involved with that, despite what some people think. There is processing in virtually every food that we do, so we need to work within the system. Again, it goes back

to having a delivery mechanism that is applicable and works for everybody.

Mr. John Vanthof: And if there was further processing involved—you've got a huge market right next to a huge producing area, but a lot of other parts of the province don't have that. Transportation is even more critical, and a further process would make a lot more sense.

Mr. Jamie Reaume: Yes. In that case, I would agree. I see the north as being the biggest venue for us being able to assist with.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll move to the government. Mr. Colle?

Mr. Mike Colle: Thank you, Jamie. My father, when he first came to Canada, came over on a contract in those days after the war, and he worked on the Holland Marsh for a number of years, near Bradford, so it's a place close to me.

The question I had is in terms of the Ontario Food Terminal Board, you mentioned that there was something there that had to be looked at. Briefly, just flag that again?

Mr. Jamie Reaume: Looked at in terms of—

Mr. Mike Colle: In terms of a change that you asked for or—

Interjection.

Mr. Jamie Reaume: Oh. I said that if you're going to do distribution hubs, you need to open up the act and take a look at it, because there are phrases within the act that preclude that. There were two pieces, actually, that talk about the Ontario Stockyards, which no longer exist, and the Ontario Food Terminal, which still exists. They are two diverse pieces, but the act, the legislation itself, is something that would allow for more of what I call an ability to put in the hubs. Those food distribution centres or hubs are legislated differently.

Mr. Mike Colle: Okay. And then the next thing you said—there were how many tons? Nine billion tons of—

Mr. Jamie Reaume: No. We brought one million tons of food inside the terminal this year, which was a record. Normally, you run anywhere from 880,000 to 930,000 tons kind of thing, but we had a million tons that ran through, which is an extraordinary amount of food.

Mr. Mike Colle: I've been involved with the Toronto international tomato festival. We're trying to promote canning of tomatoes in the Italian tradition, and it's increasing by leaps and bounds by second and third generation newcomers. But what I was trying to get a hold of—I found out how many tomatoes are produced by greenhouses. I know tomatoes are a cash crop, but how many pounds of tomatoes or bushels of tomatoes would perhaps be produced every year in the GTA or would the food terminal handles? Do we have any idea? Can we ever get a number? I've asked the ministry and they don't seem to be able to get a number on that.

Mr. Jamie Reaume: You're talking about—

Mr. Mike Colle: The Roma tomatoes, the San Marzano—

Mr. Jamie Reaume: You're talking about three different things. First, you're talking about the greenhouse,

which is a different sector. Second, you're talking about the vegetable processors, which is specifically the Romas and tomato varieties like that that go to Heinz down in the Leamington area. Third, you're talking about field tomatoes and the open crop for it.

Mr. Mike Colle: Yes—

Mr. Jamie Reaume: Availability of poundage is rather difficult to track because many of the farmers themselves don't keep a really clear record of how many they move. The greenhouse sector itself would be a little different. The veg processors you grow per pound, but the free market, what I call the fresh market—it would be virtually impossible to figure out how to get a handle on that.

The Vice-Chair (Mr. Ted Chudleigh): Good. Thank you very much, Jamie. The last numbers I saw from the processing industry: There's about 40 tonnes per acre.

Mr. Jamie Reaume: Yes.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much for coming in. Obviously, your knowledge of the industry is very helpful. Thank you.

Mr. Jamie Reaume: Thank you all.

FOOD FORWARD

The Vice-Chair (Mr. Ted Chudleigh): We will call the Food Forward representative here. Thank you very much for coming. We look forward to your presentation. As with the former presenter, you have five minutes, and that will be followed by three minutes each of questioning. Would you please identify yourself for the purposes of Hansard?

Mr. Darcy Higgins: Darcy Higgins, executive director of Food Forward.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. I'll warn you when you have one minute left. Thank you.

Mr. Darcy Higgins: Great. Thanks, Ted.

I represent Food Forward, which is a group of citizens who are working to create positive and healthy change through food. We've worked on many initiatives, including local food in hospitals, support for new entrepreneurs, including newcomer caterers and young local sustainable food superstars, and working to connect community food leaders, policy-makers and entrepreneurs who are doing great things in food.

I'm not here representing a specific industry sector but a public voice. I'm joined by a few of our members of Food Forward here today, folks from the Toronto Youth Food Policy Council, and others of the public who are interested in coming to the next meetings. Many of us who are here, including other speakers and deputants and those who have done written submissions, are also supportive of the Local Food Act and are asking to make it stronger. Local food procurement by the broader public sector is critical for local farmers and for the public who are eating the food.

The Local Food Fund that was recently announced I believe will be very positive for the food sector.

We wish that a Local Food Act would better address some of the other problems in the local food system, things like the environment, equity, health, job creation. As you know, we have deep issues in Ontario around the food system that must be addressed, like the loss of farmland, family farms, young farmers, produce production, processing infrastructure. But primarily today we are here to ask that the Local Food Act be strengthened in a way that creates more jobs, something that's critical for young people like me and across all sectors in the province. But I think we can do something in food.

1620

On the Local Food Act, we suggest considering amendments to see the act through a jobs lens. The stronger the act, the more jobs we can create. We have three specific amendments to propose, which some other MPPs and organizations have also been proposing. In a letter to Food Forward last year, the Premier committed to a strengthened act that would develop goals and targets around the production, processing, distribution, sales and marketing of Ontario food. The language of the act, we believe, should improve to meet this commitment, or else goals and targets could be up to the whim of the minister of the day. Therefore, we propose the act at least read that the minister "will," rather than "may," establish goals and targets.

The minister should also increase financial and educational support for public sector organizations in the agri-food sector to allow goals and targets to be met. From our experience working with and advising staff in universities and hospitals, institutions are at very different levels in local food procurement, and I think some government support would allow a lot to happen in this area.

Secondly, from here in Toronto to our rural communities, regulations in agriculture, public health and many other areas affect food and agriculture businesses. These regulations are difficult to follow and very complicated. Jamie would know this, as do new Canadians, for example, who are trying to start small catering businesses. A business owner I spoke with last week had dealt with conflicting stories from bureaucrats trying to figure out the system for years, and wasted a lot of money and time along the way. She started figuring things out and now has newcomers to Canada asking her for assistance. A woman who was in her restaurant business incubator a little while ago was in tears, asking her advice. She thought her business was sunk because of the issues.

Therefore, the minister should conduct a review of regulations that affect small businesses, with public consultations, and create a single-window approach to ensure regulations meet with the needs of health, safety and the environment, but are also accessible and practical for food and small-scale agriculture businesses to create new jobs.

Finally, we support Bill 68. We think it's a great idea to give to food banks. We also suggest—because community food programs are expanding these days and there are a lot of groups, a lot of charities that are also

doing very innovative work. We could talk about this more in a minute, but we believe that perhaps other charities that do community food programs, not just food banks, could be relevant for accepting donations.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll move to the third party for questioning. Mr. Schein.

Mr. Jonah Schein: Darcy, welcome. Thanks for coming in today. We appreciate your contributions to the city and the work that you've been doing, and for coming here today.

Your experience working with youth when it comes to food: I'm curious. If we were to get more public education for young people when it comes to food, in your experience, what would that mean? Can we change our buying habits, our growing habits, with a better education strategy?

Mr. Darcy Higgins: Yes. There's a real mix of the level of knowledge young people have. There is a significant interest, so I think young people are driving for more knowledge about the food system, about where food comes from, and it would be excellent to get more of that in the classroom and more food education that's practical, hands-on, that involves growing or farm tours or work in the kitchen. Things around food jobs would be very beneficial.

Mr. Jonah Schein: Have you thought about using school infrastructure for community kitchens, for example? I know that a lot of people don't have access to kitchens, and we have schools where we're already paying to keep the lights on, where we're paying for the heat, but we're not using those kitchens very well.

Mr. Darcy Higgins: Right. Kitchens are very hard to come by in the city, so the more use of schools as community hubs, even thinking about that as a commercial kitchen that could be used in the evening—I think the Toronto District School Board is interested in doing more, having more kitchens. So having those come on board for folks who need to use them in community programs would be really good.

Mr. Jonah Schein: Also, when it comes to making charitable donations, I think that's great, and farmers who do that should be supported. In your experience, though, are food banks across Ontario able to refrigerate fresh food? How often is that possible?

Mr. Darcy Higgins: A lot of food banks are doing small-scale work, some at churches and such, so I can't say exactly what the background is. I think that some others, like community health centres that are charitable but are also doing the meal programs or community kitchen programs, would have a bit more refrigeration and also be able to use the produce.

Mr. Jonah Schein: Thank you, Darcy.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Government? Mr. Colle.

Mr. Mike Colle: Thank you. I have a lot of questions and very little time. You talked about job creation with some of the newcomers who are trying to get into the business of food. What was the obstacle for that lady

there you were talking about who was trying to basically start—

Mr. Darcy Higgins: This was in your riding, actually. I work with Josh Colle on some of these projects. It was figuring out the use of kitchens and some of the public health regulations. In your area and others, there are a lot of folks who are doing stuff at home, maybe under the radar.

Mr. Mike Colle: Yes, in their basements and stuff.

Mr. Darcy Higgins: Yes. I think the woman who has a business now in the riding had been told that she could just have another kitchen, so when she got another house, she had the two kitchens, but it was then on the second floor. Public health hadn't told her initially "no." So all of this investment went into putting in two kitchens and it wasn't in the right place and couldn't be done.

Mr. Mike Colle: I'm just thinking of all these stories over the years. I remember that there was a Portuguese gentleman who had a business in the garage. He was doing the Portuguese churrasco potatoes. The neighbour next door was complaining that these big transport trucks were coming weekly and he had a forklift and three or four people working in the garage peeling potatoes. They were trying to close him down and I was trying to explain to the building inspector, "This guy is hiring people. Is there any way we can accommodate him?"

Then there was also the example of Grace Street. There was a Chinese family in the basement doing chicken preparation for a Chinese restaurant on Bloor. I walked in and said, "Holy God." What can we do to sort of get that legalized?

Mr. Darcy Higgins: What about 30 states in the US have done are called cottage food laws. They've done a review and passed these laws allowing the basic, safer foods. You probably wouldn't be able to do chicken in your basement, but something like basic baked goods or a pie that you might do at a church sale or a fall fair type of thing, and that would give a good start to a lot of entrepreneurs to figure out some things that they could do. Those are American cottage food laws.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll move to the official opposition. Mr. Hardeman?

Mr. Ernie Hardeman: Thank you very much for your presentation. I just want to start off by saying that obviously you agree with all of the parties at this committee hearing in support of the food act. At least most of us want to do the best we can to make it do as much as it can. When the minister suggested, "We will reintroduce it, but a stronger food act," I think that some of the things you mentioned are what would make it a stronger food act. I think that's what we are collectively looking for.

You mentioned the issue about—rather than "may" set goals and targets or ask the stakeholders to set goals and targets, you're suggesting that it should read "shall" set goals and targets. If that change was made, what do you envision those targets looking like? Can you set targets if you don't know what the balance of Ontario food to other

food is now? How do you set a target to improve on that and so forth? Can you try to give me a feeling of how you think that should be set?

Mr. Darcy Higgins: There is a lot of research, and that baseline data, I think, has to be done. What I think we could at least do is say, "Yes, we will set goals and targets," rather than the minister "may" at any time do it. I don't know if we should have numbers in the act, because we're in different places with different sectors and different parts of the province or what "local" means in different areas. So there is a lot of research to be done by different groups of institutions with the government or with the public service on this, but if it's in a stronger way saying we will, within a few months, work on the development of these targets.

1630

Mr. Ernie Hardeman: The other thing I'd like to ask: You mentioned about broadening the ability of the tax credit to more than just food banks. Could you give me some examples of what you would include in that as other groups in the community?

Mr. Darcy Higgins: Sure. I believe it's in the brief that I gave; I gave some examples. I would say community food programs could be programs that run community kitchens. These are becoming much more popular around the province, where folks are involved in creating the food themselves and cooking, not just being handed the can or the produce but developing that, cooking, then bringing it home or eating as a community. Or perhaps active living children and seniors' programs, a lot of programs that may be giving a snack for an after-school program in a community that adds health—

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Mr. Higgins. We appreciate you coming in and bringing your perspective to the committee.

Mr. Darcy Higgins: Thanks, everybody.

ONTARIO FEDERATION OF AGRICULTURE

The Vice-Chair (Mr. Ted Chudleigh): We will now move forward with the Ontario Federation of Agriculture and your presentation: Mr. Wales and Mr. Lambrick. Welcome to the committee. You'll have five minutes to make your presentation, and then three minutes from each of the parties to question. We look forward to your presentation. Would you please identify yourself for the purposes of Hansard.

Mr. Mark Wales: Good afternoon. My name is Mark Wales, and I am the president of the Ontario Federation of Agriculture. With me today is Peter Lambrick, a board member.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much.

Mr. Mark Wales: First off, I'd like to thank you for this opportunity today to address the committee regarding Bill 36, the Local Food Act. We are pleased to provide our comments on this important piece of legislation on behalf of OFA members. Our over 38,000 farm family

members come from all types of farming operations, and from the backbone of a robust food system that drives the Ontario economy.

The OFA supports the intentions of Bill 36. We believe that this legislation presents an opportunity to build lasting support for Ontario's farming and food sectors. Promoting awareness and striving to improve local food procurement is a great start, and should be endorsed through this legislation, but the goals of the act should not stop there. We believe that Bill 36 can and should do more.

Allow me to put this comment in context. The OFA and its national and provincial colleagues have done considerable work in developing a strategic approach to our food system. We have created a national food strategy—and you all have a copy of that document, so enjoy it. The national food strategy is a vision for farming and food that focuses on long-term solutions to the significant and evolving challenges that we face today.

While national in scope, the strategy presents a number of key objectives that are under provincial authority. The national food strategy envisions a future where Ontarians will always have access to safe and nutritious food, and that consumers will choose foods that lead to a healthy lifestyle. Essential to achieving these objectives, we need to invest in food awareness programs, to create education campaigns to encourage Ontarians to value food as a source of nutrition and to avoid waste. Human health and illness prevention starts with a strong food literacy component in our school curriculum and ends with a healthier population and a less taxed health care system.

We believe that Bill 36, the Local Food Act, can be the first legislative initiative that addresses these goals of the national food strategy. Local procurement is an important part of that, but we suggest that the opportunity now exists to pursue a more ambitious bill. The OFA has been very clear since the introduction of this act that it can and should have a broader impact by including targets for improving food literacy programming in our schools, by addressing improvements in food access and by providing support for local economic development initiatives based on food systems.

The Local Food Act also presents an opportunity to impact local food production and marketing by changing the approach to the property tax assessment of agricultural value-added activities. In the interests of growing our local food supply, we propose that the property tax treatment of value-added facilities give special consideration to products grown in Ontario. The OFA policy on property taxation of value-added facilities states that if, historically, at least 51% of the product is grown and value-added to by the same farmer or farmers, and at least 90% of the product is grown in Ontario, then the facilities should be subject to no more than 25% of the residential property tax rate—i.e., the farm class tax rate. If the Ontario government wants to effect real change in the availability of local food products in our food

systems, this definition should be incorporated into the Local Food Act.

With regard to local food systems, the OFA wishes to again acknowledge the tremendous benefits of the \$30-million fund that is now available in support for local food systems from the Ontario government. This is an excellent initiative to help jump-start the goals of the many thousands of Ontarians who have become engaged in and enamoured by Ontario's local food. OFA firmly believes these amendments will help Ontarians to develop a better understanding of the importance of local food, its value to the economy and its benefit to human health.

I would like to thank the committee again for this opportunity to comment on Bill 36. We look forward to working with you on Bill 36 with regard to its current goals and to expand our efforts to secure a healthy future for food in Ontario. We also invite you to review the national food strategy and its goals and objectives, and have happily provided copies for all committee members.

We will be hosting a reception starting at 5 o'clock upstairs. I'd love to see you all there.

The Vice-Chair (Mr. Ted Chudleigh): We'll look forward to that. Thank you very much.

Can we start with questioning from the government side? Mr. Colle.

Mr. Mike Colle: Thank you very much for the very thoughtful presentation. I want to discuss with you at length sometime—a tomato farmer told me, "The real root of the problem with a lot of the things we have with food in this county is that we have a cheap food policy. If people really appreciated the real value of food, we would start to pay people who work in agriculture, be they farmers or workers, what they really are worth." I'll get into that later with you, but it was really thought-provoking, I thought.

The question I had is about your tax treatment there. Could you just explain that again, just so that I'm clear about the change? If someone adds on a processing element to their property, they would get a tax treatment that would be 25% of the normal assessed rate?

Mr. Mark Wales: Two things to go along with that: The first thing is the act that MPAC use to assess buildings on a farm has no definition for "primary agriculture" in it. Currently, if someone does a value-added activity, so does something that will help retain the value of the product—washes it, chills it, dries it, whatever—if they trigger a building permit and a visit by MPAC, they usually get assessed either "commercial" or "industrial." That increases the tax rate by either times seven for commercial or 10 for industrial.

We need to first get the definition of "primary agriculture" resolved. We've been working on that for quite some time, and we've had agreement from MPAC and the Rural Ontario Municipal Association as well as all the commodities on how to go about doing that. Once that is done, then we need to address how we deal with value-added activities, which typically will fundamentally change the product itself—so you're transforming it

into something else. The best example I can come up with is making fruit wines. You're taking fruit and making wine out of it. Typically, what happens is that they get assessed usually industrial, and probably nine out of 10 times, that causes that business to cease.

We need to get that dealt with. You've got to deal with the "primary" definition first; then we can address value-added and find the fairest way. We're suggesting as our policy that it be the same as farmland, which is 25% of the rural residential tax rate.

Mr. Mike Colle: Okay. Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Mr. Hardeman.

Mr. Ernie Hardeman: Thank you very much for your presence here today and for the presentation. If I could ask, first of all, if you could make sure that—you don't have to change the time your reception starts, but if you could make sure that it goes long enough so that this committee can finish its work before you close shop—

Mr. Mark Wales: We'll make sure we keep some stuff for you.

Mr. Ernie Hardeman: Thank you very much.

I appreciated the comment from the government side. I think it's important; the issue of taxation on value-added farm buildings has been ongoing for some number of years, and it doesn't seem to be moving forward. I hope that through this process, we can move that along, although I don't think that's really the thing—it's got to go into the finance bill to make sure that it doesn't get lost in translation when MPAC is implementing it.

I do want to go a little bit to strengthening the act. In your mind—as you said, you agree, as we all do, with the act. But if we change nothing, what is it that the federation of agriculture would think the benefit of this act is going to be?

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Mr. Mark Wales: Again, the act itself is designed to raise the awareness and the importance of local food. I think my comments included mention that we need to make sure that food literacy is key. We have a generation or more who fundamentally don't know how to make a meal. One of the goals we set out in the national food strategy is that if 16-year-olds were able, at the end of the day, to cook six nutritious meals from scratch, they would, first off, understand what nutritious local food is, and they would have to go out and purchase it, so they would really understand it. That would go a long way to helping them understand. People don't know how to cook anymore. We've lost that in our society, and if we keep going, we'll lose it forever.

Home canning is another thing—again, in my farming operation, I grow quite a large number of vegetables. We have a large pick-your-own operation. I have a lot of Italian customers that come all the way from downtown Toronto to get their Roma tomatoes, so I was interested to listen to the member's comments earlier—

Mr. Mike Colle: Hundreds of millions of tonnes.

Mr. Mark Wales: And it's a shame. So what I do is, I have the local food bank out of London come and glean

the field when we're done. One of the challenges is that the people who are getting that product at the food bank have lost the skill of canning as well. So we've had some good support, actually, from the canning industry, which is willing to help.

People need to know how to cook, they need to know how to can and preserve it, and they need to understand how important local fresh food is to their better health.

Mr. Ernie Hardeman: We need more food literacy.

Mr. Mark Wales: Definitely.

Mr. Ernie Hardeman: There we go. Thank you.

The Vice-Chair (Mr. Ted Chudleigh): The third party?

Mr. John Vanthof: Thank you for coming, Mark and Peter. You've done a really good job of identifying one roadblock to local food: the tax implications. It might be too specific for the Local Food Act itself, but I believe it sets out that the minister must set out targets and goals. Could we perhaps have, as one of the things that the minister should look at, a timeline in looking at the roadblocks that affect local food accessibility and the profitability of local farmers and processors, and set a goal of that and a timeline to look at it and possible objectives to removing those roadblocks?

Mr. Mark Wales: Objectives would be a very good thing. One of the challenges is, if you don't set targets of some kind, then it's hard to measure your progress.

One thing to make sure is that when you're setting targets, and depending on who those targets are for, you don't create an overly burdensome reporting requirement. There has been some suggestion about—I'm just trying to remember the topic. I thought I would have had a question on it, but I guess not. The tax credits for glean-ing, again—I was talking with Ernie about this last night and this morning. If that happened to go through as an amendment, my concern would be just to make sure it doesn't place an excessive burden on the food banks themselves.

So it's about process, nuts and bolts. I'm very supportive of the concept; we just need to make sure it works. But at some point, you need targets of some kind.

Mr. John Vanthof: But as an overarching piece of legislation, this could be used to direct other parts of the government to look at areas that are hurting them, like over-regulation. Things like municipal taxation can't be addressed within the Local Food Act. But the problem could be directed so that we look at the overall problems that face agriculture within a timeline to see how we can fix them, so it won't fall through the cracks again.

Mr. Mark Wales: I agree. One of the biggest challenges that face my members is over-regulation. We've been working with the government through the Open for Business process. I look forward to that process continuing to work to deal with those regulations, because we are the sector of the economy that is regulated by the most number of ministries and the most pieces of legislation. We recognize that we need rules, and that's what differentiates our products. But we need rules that

work for us, and we need to make sure they're consistently and fairly enforced.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Mr. Wales, for coming in and sharing your views. I appreciate the federation of agriculture's position. And thank you, Mr. Lambrick.

Mr. Mark Wales: Thank you.

ONTARIO GREENHOUSE VEGETABLE GROWERS

The Vice-Chair (Mr. Ted Chudleigh): We'll now move to the Ontario Greenhouse Vegetable Growers and welcome Mr. Don Taylor. How are you today, Don?

Mr. Don Taylor: I'm fine. How are you, Mr. Chairman?

The Vice-Chair (Mr. Ted Chudleigh): I'm very good, thank you. You have five minutes; I'll give you a one-minute warning. Then we'll move to three minutes each for the questioning. If you could identify yourself for Hansard, too, please.

Mr. Don Taylor: I'm Don Taylor. I'm the chairman of the Ontario Greenhouse Vegetable Growers. I thought I had 14 minutes. If I have five, this is not going to be pretty, so I'll get going.

The Vice-Chair (Mr. Ted Chudleigh): You can use the rest of it in your answers. It's okay.

Mr. Don Taylor: I've provided a handout there that provides the detail that I would have gone over. There is some information there on the greenhouse sector, for those of you who aren't aware of the magnitude of the greenhouse sector.

We represent about 2,300 acres of greenhouse vegetable production in the province. We employ a little over 10,000 people. Our farm gate sales are approaching \$800 million this year. So it's a very big sector. It's also an expanding sector, which is not the case with all agricultural sectors. We added a little over 200 acres to our production base in 2012, and at close to \$1 million an acre, that's a significant investment in the provincial economy.

The other point I just want to make in terms of background is that the greenhouse vegetable sector, like all edible horticulture sectors in Ontario, competes domestically and in export markets in a very free-trade environment, and I'll underline the word "very" there. In our case, about 30% of our product is marketed domestically and about 70% is exported. It's that domestic portion that is our most profitable, and it's that domestic portion that is the springboard for all of our exports, which really bring in revenue to the country and to the province.

We are certainly in favour of anything that increases Ontarians' knowledge of their food and where their food comes from, and helps to promote the replacement of import foods with domestically produced foods.

I'm just going to make a few comments on recommendations, and these are bolded in your outline. The first one relates to the overall legislative approach. We cer-

tainly appreciate the approach that's taken in this act, and that is, in broad terms, we would prefer to see education and awareness, not regulation. We're particularly concerned that regulation not go into areas that might be questionable under trade agreements. If we started to require some of our public institutions to purchase Ontario foods, we could be starting to step over the line in terms of some of our trade requirements. For a sector that exports 70%, we don't want to do anything to threaten trade, particularly with the US.

In the rest of my comments, I'm just going to focus on the three broad purposes listed in Bill 36.

First of all, fostering successful and resilient local food economies and systems throughout Ontario: We very much support the creation of a government authority to establish targets and to require mandatory reporting from Ontario public sector organizations. As I said, we don't want to see that go into regulation. In fact, reporting could be very useful to us. If they're not buying Ontario, we'd like to know why, and maybe it's something we're doing that we can improve upon, to improve that for public sector organizations.

We also support the creation of appropriate recognition incentives to help those further along the chain to realize the importance of sourcing Ontario products. Any of you who have gone to the annual Foodland Ontario awards ceremony will know how well that works in terms of getting retailers' attention.

The second purpose, increasing awareness of local food in Ontario, including the diversity of local food: I guess the main thing is—if I had no other recommendation, this would be it—we think the government has an excellent program in the Foodland Ontario program. We encourage them, through the Local Food Act, to get the most out of that program, and to maintain and support that program to the greatest extent possible.

There are some things that—if we could recommend changes in the Foodland Ontario program, we certainly would. One area that I think we need to focus upon comes from the success of the program. Ontarians are now looking for Ontario-produced foods, so there is a temptation for some of those further along the chain to market non-Ontario-produced foods under that label. We think there needs to be a little more policing there.

We also concur very much with the definition of local food as "food harvested in Ontario." We don't want to see the definition go any further down than that. One of the major purposes is displacing imports with Ontario-produced foods, so we think that should do it.

In terms of the third purpose, encouraging the development of new markets, I guess we would suggest that, if possible, we look at broadening Foodland's mandate to look at restaurant and food services, something that we're looking closely at. Secondly, although perhaps outside of the mandate of the Local Food Act, exports help support local food and the competitiveness of local food, so we would also encourage the government to look at programs that could help build exports.

Thank you.

1650

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Wonderful condensing from 14 minutes.

We'll move to the official opposition. Mr. Hardeman.

Mr. Ernie Hardeman: Thank you very much, Mr. Chairman, and welcome, Don. It's good to see you again.

I was encouraged to hear you talk about Foodland Ontario and how well it works. In fact, it is the number one recognized brand of anything. Of any branding exercise, Foodland Ontario is number one. Yet the average consumer does not know that all Ontario food is not part of Foodland Ontario.

Would you suggest that it would be a good idea if we included things produced in Ontario to be from Foodland? If it's edible, it should be part of the government's initiative to encourage local food to be consumed?

Mr. Don Taylor: Traditionally, Mr. Hardeman, if you go back, Foodland Ontario was for fresh produce, and there were some reasons for that. But a few years ago, the government expanded that mandate and allowed it to be used for other Ontario foodstuffs. Certainly, as the original owners of the brand, I guess, we would support that broadening.

You do run into complications when you start to get into processed food, in terms of what is the definition of an Ontario-produced food. So you could have a processed food that's primarily foodstuff grown outside of Ontario and the final packaging is done in Ontario. I know this act speaks to the potential for addressing regulations that would define that. So to the extent that you can clearly define what an Ontario-produced food is and, from a farm standpoint, it contains primarily Ontario farm-produced ingredients, we would support the broadening for sure.

Mr. Ernie Hardeman: The other thing I just wanted to quickly touch on: The Ontario Greenhouse Vegetable Growers recommend "that the objectives/purposes of the ... act can be best accomplished by encouraging education, awareness and promotion of Ontario-grown food and not by a regulatory approach." Do you think the present act does enough to actually achieve anything?

"Encouraging education": It doesn't seem to encourage education at all. In fact, the word "education" is not prominent in the act at all. I was wondering if you could just comment on that a little bit.

Mr. Don Taylor: Well, I think at least one of the purposes of the act does speak to increasing awareness, and I guess I'll use that as consistent with education. Admittedly, there could be more done by the act, but I guess we see it as a starting point, and hopefully it can be built upon from here. And we are encouraged by those three broad purposes, for sure.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much.

The NDP. Mr. Schein.

Mr. Jonah Schein: Thanks, Mr. Taylor, for coming in. I'm curious to hear you talk about impacts of NAFTA and so forth, but then mention targets, but that would be non-binding. I'm curious to know what the impacts of

targets would be. How would they be used if they were not binding in any way?

Mr. Don Taylor: Particularly for public institutions, Mr. Schein? Is that what you're asking?

Mr. Jonah Schein: Sure.

Mr. Don Taylor: I think that a person who manages one of the public institutions outlined in the act has to pay close attention when the government is advising that it would like them to set a target and then provide ongoing reports as to how they are doing in terms of achieving that target. So we think that's quite a bit of encouragement for public sector organizations.

We do think that if you go further and absolutely require it, you are going to run into potential problems with trade—and we've had issues with some of the US policies with respect to this—but you're also going to run into issues with the mandate of the organization. I mean, if they're supposed to live within a budget and do the best they can, if they can't do that with Ontario food—that's the other part of it that I would mention—I think we'd like to know why, because maybe there's something we can do better to help them reach their targets and help us reach our targets. So that report back to us is an extremely effective tool to help make that happen.

Mr. Jonah Schein: And keeping statistics on how much local procurement is actually in our public institutions—would that be helpful?

Mr. Don Taylor: Exactly.

Mr. Jonah Schein: The idea of food labelling: Do you have further ideas? What would that look like to support, to increase food labelling, or is that what you're saying?

Mr. Don Taylor: This relates to my comment on policing Foodland. Is that what you're—

Mr. Jonah Schein: Go ahead.

Mr. Don Taylor: Some of this is just accidental at the retail—that's what they always tell me when I bring it to their attention, anyway. But you do get bin wrap around bins that might have contained Ontario product at one time but now contain Mexican, and it still says "Foodland Ontario" on the bin wrap.

We've worked hard with Foodland Ontario, both the government and the sectors, to get Ontario citizens—when they see that symbol, they know that represents food grown in Ontario. Well, if it doesn't, that's misleading.

Foodland Ontario has survived so far without much of a policing program—without any policing program, but we think all of this is not accidental anymore. Ontario citizens are looking for Ontario food, and they're being misled. So we think that there needs to be a little bit of policing of that brand.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much.

Moving to the government side, Mr. Crack.

Mr. Grant Crack: Thank you, Mr. Chair. Thank you very much, Mr. Taylor, for coming. I know you've talked about it previously—trade agreements, trade requirements, trade obligations. That's an important component

of why the bill has come forward as it has. Our concern is setting targets that could compromise potential obligations and obviously have an impact on your particular business.

You've indicated that you export 70%. Could you maybe just elaborate perhaps on what set targets—if they were excessive? If the committee was to receive amendments and consider those and pass, what would that mean to your organization?

Mr. Don Taylor: I'm not sure if I understand the question, Mr. Crack, but I think setting targets is not setting a requirement. It's setting a target and then having to report back on how you're doing on it. So it doesn't mandatorily require that you meet that, which we think should meet our trade obligations. There's nothing wrong with encouraging—in fact, that's what Foodland Ontario does now. But you'll have to understand that our sector lives in mortal fear of that border being closed. Fresh produce is only fresh for a day or two, and if the border closed for five days, we would potentially have millions of dollars of produce that would have to be destroyed.

So we think setting targets and we think requiring reports back are very useful, but if one goes beyond that, you're going too far, in our opinion.

Mr. Grant Crack: Okay. Well, thank you. I think Mr. Colle wants to ask about tomatoes.

Mr. Don Taylor: We have 420 million pounds of tomatoes produced, Mr. Colle.

Mr. Mike Colle: I got it from you guys, but I couldn't get it from the cash crop sector.

The question I had is, you know the packaging? One of the problems I have is that I need my glasses, it's so small. I'm trying to find out, is this an Ontario product or is it from Mexico? If we could get some good-sized Canadian Tire lettering on that so I can see "Ontario" on it. That's what I find over and over again: This small print is driving me crazy.

Mr. Don Taylor: I concur. In fact, it's complicated further. Probably most Ontarians don't realize this, but there are a number of the marketing companies that grew up with the greenhouse sector that still market the majority of our product. But they also bring in product from outside Ontario and market it under the same label—not under "product of Ontario." If you check closely—and put your glasses on—it can be a little hard to tell which is which, and anything we can do to improve the consumer's ability to know that is critical because we think the consumer is getting more and more convinced that there's a reason to buy Ontario.

The Vice-Chair (Mr. Ted Chudleigh): Good. Thank you very much, and thank you, Mr. Taylor, for coming in today. We appreciate your input.

GREEN THUMBS GROWING KIDS

The Vice-Chair (Mr. Ted Chudleigh): If we could move now to Green Thumbs Growing Kids. Welcome to the committee. You're to have a five-minute presentation, followed by three minutes of questioning. I'll give

you a one-minute warning, and if you could identify yourself for the purposes of Hansard.

Ms. Sunday Harrison: My name is Sunday Harrison. I'm the founder and program director of Green Thumbs Growing Kids. We're a community-based organization in downtown Toronto.

Thanks for the opportunity to present my views on proposed Bill 36. My comments will be oriented primarily to the second objective of the bill, which is to increase awareness of local food in Ontario, including the diversity of local food. I want to say that I appreciate the inclusive wording of that objective because what grows in Ontario includes a lot of foods that were perhaps not grown by either First Nations or European settlers, and gardeners and farmers are learning what can be grown here from other parts of the world and how to prepare it. So I appreciate that.

I read through the comments in the debates before this bill came to committee, and it's clear that many people already agree on increasing food literacy in the policies that govern Ontario.

1700

I relish the opportunity to inform the committee of what food literacy on the ground looks like—sorry for the pun. For 13 years, our small community-based charity has partnered with schools to create gardens on school property and to lead workshops in the school gardens. In winter, we make healthy soil with food waste and worm bins in classrooms. In spring, of course, we plant. In summer, we run garden programs for all ages. In the fall, the students harvest and prepare recipes from the foods that they grow, including potato dishes, kale chips, salad rolls, pesto and salsa. We just had a brilliant workshop today, making salad rolls in the garden; it was just lovely.

Every season we offer hundreds of these garden-based workshops at three or four local schools. We do it with very little public money, yet it is public school students who benefit. We use federal and local wage subsidies to hire youth to help run the summer programs and keep the gardens productive. Staff and volunteers run everything on less than a shoestring, out of commitment to the idea of food literacy and environmental literacy.

Food in schools is a critical issue that knows no ideology, class or ethnicity. How we educate is critical for our democracy to have meaning, and the physical health of our children is critical to how well they learn. We know that hunger is an issue, but it is not enough to simply dump more packaged low-nutrient calories into schools. Students need to know where food comes from, and how and why to choose healthy foods. They need to know this from their own experience.

If Canada's Food Guide alone could teach healthy eating, we wouldn't have a problem with kids eating too much junk food. The problem is more complex. Adding food literacy to the curriculum means, to me, adding hands-on activities to increase student knowledge through experience, because Canada's Food Guide is already in the curriculum; it's taught at every grade. It's not enough. We're in the second generation of people

who do not have the basic food skills that predate the microwave and the single-serve plastic package.

Kids who have never tried fresh local foods have no way of knowing how good they taste. And growing your own connects you to the food in a deeper way from taste to waste, meaning you taste it more and waste it less. Research shows that children and adults alike eat better when they grow gardens, even in short seasons such as in Ontario's north. But we also know that school gardens are more about taste and supplementation and less about provisioning, unless it's just one crop.

The cost of healthy food should be supported through revenue tools only available to governments. Local procurements and supports for local, regional, municipal and school board partnerships with farmers should be included in the proposed Bill 36.

We propose that the following amendment be added to the bill: "The minister shall consider goals or targets related to food literacy and the use of school food gardens in the furtherance of the purposes of the act."

In 2010, the government introduced P/PM 150, which limited junk food in schools. It was called "comprehensive," but in fact it only dealt with part of the problem. A real example of comprehensive legislation is the 2010 Healthy Schools Act from the District of Columbia. This 37-page legislation exemplifies a far-reaching vision in food literacy and includes provisioning, local procurement—which is well-defined—school garden grants of up to \$10,000 per school, universal feeding programs, environmental initiatives, and physical activity. I brought a copy; I didn't bring 20 copies, because this is a lot of pages. I'm sure that some of the issues are a little different in terms of trade, but some of them aren't, so it could be very relevant in terms of planning a more fulsome policy.

Local Food Week might set good directions in terms of policy, but with all due respect, we already have some great policy frameworks that are much more developed than naming a week but are still largely unimplemented.

In 2009, this government passed the policy framework Acting Today, Shaping Tomorrow, which commits Ontario's education system to teach environmental sustainability in every subject in every grade and explicitly names food as a subject for environmental study.

The Vice-Chair (Mr. Ted Chudleigh): Ms. Harrison, your time is expired. Perhaps you could work the rest into some of the questions that come up. We could move to the NDP to begin that questioning.

Mr. Jonah Schein: Thanks, Sunday. Thank you for coming in. I know that the work you do in my community is really important to the kids there, and I appreciate that.

I was excited to talk with you months ago about what we could do with proper resources. I think, through debate in the House, you heard people talk about the benefits of food literacy in schools. What you didn't hear probably was, actually, any commitment to resource those programs. I think you're astute in noticing that it

should cut across ideological perspectives, that food literacy can be considered back-to-basics—from some of my friends from the Conservatives here—but that it needs support and funding.

I wanted to highlight something that you said, which is the idea of goals and targets for food literacy in schools. I think that's really important, but what could you do with more resources in the schools? How many schools could you be helping? What more could you be doing? What are the impacts on students right now through the food education that you're having? What could happen if your dream of a garden in every school was realized?

Ms. Sunday Harrison: Yes. What was the question?

Mr. Jonah Schein: If you were not just doing this on a shoestring, if you actually had government support to help kids in this province learn about food—

Ms. Sunday Harrison: When we see a really beautiful garden-to-culinary program, like in spring and fall, and the community programs in the summer, I think it's just the opportunity. Really, what's at the core of it is the opportunity for each child to have that ownership and agency, a full sense of engagement with something that tastes good and smells good and isn't candy; it came from the ground. And then you planted a seed, and—oh my God!—you got something you could eat. There's a magic in that.

It happens between us. I think we're all of a certain age where we probably had that experience, but kids these days are not getting it, and that's what I think the beauty is: that really magical moment when you're young enough that it matters. It really matters to your later development and your later understanding of what healthy local food is.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Mr. Colle?

Mr. Mike Colle: I certainly think we all agree that this hands-on approach is critical, through the schools. Hands-on learning, I think, is where everybody learns in a much better fashion.

You said also, which is very important, that the new world foods are being grown in Ontario—I know that now soybeans are going to take over corn as the number one crop grown in Ontario. Who would have believed 10 years ago that the soybean would be so—there are changing opportunities. Bitter melon is an incredible new crop that the Asian community is getting into. There is an incredible education value in understanding the impact of world foods in our diverse communities.

But the thing about schools—and I totally agree. I know I've got the gardens at my Toronto Community Housing project; they have outdoor gardens. But don't you think there have got to be more attempts to have children visit farms on a regular basis? I find that if you ask children—they go through eight years of grade school—they may have gone to a farm once and it was the farm up there at York University. What's it called?

Interjection: Black Creek.

Mr. Mike Colle: Black Creek. That's the only farm they ever saw. Is there any way that you think we could push farm visits, stays and activities for children?

Ms. Sunday Harrison: I think that's extremely important. Part of the problem is the cost of the bus. We would love to actually do a program where we would take grade 3 kids, go up to a farm, plant a long row, bring them back in Grade 4, harvest it and bring it back to school so they actually had a relationship with a farm, but that's a thousand dollars for a bus. You have to be really balancing some tough priorities in exposing children.

I think part of the beauty of school gardens is that it is more day-to-day, not to take anything away from what you are saying. I think there is enormous value in seeing crops produced on a much more farm scale. Understanding that, they only see the garden. It's not a complete picture of the food system by any means. It's the sensory piece, but it doesn't show the actual food system in a broader way, so I absolutely agree that that would be wonderful.

It would be wonderful if it was tied to farm-to-school provisioning, which I think has legs regardless of international trade obligations.

Interjection.

Ms. Sunday Harrison: Well, the farms make an arrangement with the school board to provide certain produce to that board.

Mr. Mike Colle: Okay.

Ms. Sunday Harrison: I think it can be done regionally, and you guys can figure out how to not trip any switches in the international trade. I think they have done a lot of this stateside, and I'm sure there are people who will come before your committee who know a lot more than I do about that side of it.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Mr. Hardeman?

Mr. Ernie Hardeman: Thank you very much for your presentation. Just on the issue of school trips for children, I come from a rural area and, in fact, they have almost totally cancelled the ability of children to visit the farm, for safety reasons and so forth. My position here—my direction, really—is to put as much emphasis on education and food literacy in the schools to make up for the fact that they are not going there on field trips anymore. The only way they're going to understand how food is produced is to put it in the curriculum in the schools.

1710

I was interested in the part of your presentation on how in 2009, the government passed a policy framework to mandate that we would have this in the schools. It must not have been a mandatory subject in the curriculum for it not to be implemented. Could you just highlight what you think we need to do to make sure not only that we write a good policy and give good direction, but we actually see it happen?

Ms. Sunday Harrison: I think the problem is the curriculum is overloaded, so you need to actually find ways to bring it together and to reintegrate strands and expectations. Food is a marvellous way of doing that. I did make deputations when the ministry was revising the healthy eating curriculum to do just that, but it's not

enough, because they took each review subject by subject. To actually use food as a cross-cutting inquiry has enormous potential, but I think the ministry needs to see curriculum development in a broader way again, which they did under the environmental piece, where all curriculum now has been filtered through that lens.

But again, we don't measure that. We haven't looked and said, "Okay. Well, what do children know about the environment now that they didn't know before Bondar?" We haven't done that. There is no target. There was no analysis of how we were going to measure environmental learning.

My fear with food literacy is that we could go down that same path, where it looks good on paper, but teachers are just like, "What? You want me to do what now? What?" And food is kind of a bottomless pit, probably, from their perspective.

"Awareness" and "education" are not synonymous when you're getting into the formal system, so how are we going to make sure that what happens in schools is actually meeting the needs of the education system as a whole? I think it's great to have it on the table as far as the Local Food Act goes. Again, using food as a way to integrate curriculum strands has way more legs than putting an add-on to say, "Okay. Well, now you have to teach something new," because they have too much to do.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Ms. Harrison, and thank you very much for bringing your passion and your knowledge to the committee.

Ms. Sunday Harrison: Thank you.

CANADIAN ENVIRONMENTAL LAW ASSOCIATION

The Vice-Chair (Mr. Ted Chudleigh): We'll now move to the Canadian Environmental Law Association. They have presented us with a presentation, and it's in your pile. You'll have to go through the information you were given—

The Clerk of the Committee (Mr. William Short): A written submission.

The Vice-Chair (Mr. Ted Chudleigh): A written submission.

Thank you very much for coming in, sir. You'll have five minutes for a presentation and three minutes for questioning from each of the parties. I'll give you a one-minute warning on your presentation. If you would identify yourself for the purposes of Hansard.

Mr. Joseph Castrilli: Thank you, Mr. Chairman. My name is Joe Castrilli. I'm a lawyer with the Canadian Environmental Law Association. I'm just going to have a bit of local water, if you don't mind, before I start.

The Vice-Chair (Mr. Ted Chudleigh): Local Lake Ontario water. Be careful.

Mr. Joseph Castrilli: Mr. Chairman and members of the committee, the Canadian Environmental Law Association is pleased to appear before you this afternoon to

discuss Bill 36. CELA is an Ontario legal aid clinic that represents individuals and citizen groups in the courts and before administrative tribunals on a wide variety of environmental matters. As a legal aid clinic, we also engage in various law reform, public education and community outreach initiatives. We have a long history of involvement in respect of laws and policies specific to the issue of food security, and we regard local food as part of that.

CELA welcomes the introduction of Bill 36 by the government because strengthening local food systems can have many positive benefits for Ontario's environment, economy and health. CELA also submits, however, that much more can and should be done under the authority of a bill designed to foster local food in the province than Bill 36, as currently written, may be capable of achieving.

In this regard, we would refer the committee to the February 2013 local food model bill that CELA drafted that we provided to the committee last week. CELA's model bill provides detailed and comprehensive provisions addressing such matters as targets, accountability, procurement, education, distribution and governance. We urge the committee to consider all of the association's model bill provisions as potential amendments to Bill 36.

The remainder of our written submissions focus on a few key issues such as:

- the need for a mandatory obligation in section 4 of the bill to establish local food targets and goals;

- the need for more frequent reporting by the government, pursuant to section 6 of the act, than once every three years;

- the need to develop a local food strategy so as to provide clear and concise information to the public about the government's vision for, rationale behind and means of achieving the purposes of the act; and

- the need to develop much more robust governance with respect to local food system development.

Time doesn't allow me to address all these issues, but for greater detail and specific wording on all of these issues, plus a variety of other matters that should be addressed in Bill 36, we urge committee members to review both our written submissions and the association's model bill.

Subject to any questions you may have, those are my submissions.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, sir. We'll move to questioning by the government. Mr. Colle.

Mr. Mike Colle: Thank you, Mr. Chair.

Just in terms of your model bill, it was essentially presented to us just a week ago. When was it—

Mr. Joseph Castrilli: The model bill was drafted during the last half of 2012, and it was released in February 2013.

Mr. Mike Colle: Okay. Has there been any kind of update from other provinces or the national government on this, because I know there is an attempt to look at a national food strategy too? Would this be applicable to

maybe also working toward a national food strategy, or is it more contained in a provincial domain?

Mr. Joseph Castrilli: Well, it was designed to be a statute for the province of Ontario. It takes into account certain matters that go beyond the borders of Ontario, but for jurisdictional purposes, obviously it stays within the four corners of provincial law.

Mr. Mike Colle: Okay. Given where we're at with this bill and, you know, your model bill, what do you think is the main thrust, let's say, of CELA's bill that would be something we could work on to implement that would start to move us toward your bill? What would you think is the key area?

Mr. Joseph Castrilli: Well, I think the matters I addressed in my written submission, which is the shorter of the two documents you have before you, would be a place to start.

It's hard for me to pinpoint just one area, but I think the issue of governance would certainly be important as a whole, in terms of developing a structure within government. I'd like to analogize it to the spokes of a wheel: The local food regime is the hub of the wheel, and the advice the regime may obtain from various sectors is the spokes of the wheel. That's something we tried to design when we put in, I believe, part II of the bill, and in particular sections 6 and 7: the local food systems committee and the advisory council on local food policy. Those would be places to start if you wanted to try to expand the ambit of Bill 36.

But I'm not here to suggest only doing one thing; I'm here to suggest doing a lot of things. That's why the model bill was drafted in the first place.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll move to the opposition. Mr. Hardeman.

Mr. Ernie Hardeman: Thank you very much, Mr. Chairman, and thank you very much for your presentation.

Going to the question that Mr. Colle asked on the timing of your bill recommendations, that would have been between the first introduction of the Local Food Act and the reintroduction of the Local Food Act. In timing, would that be right?

Mr. Joseph Castrilli: I think that's right, because if you look at the model bill, it actually has footnoted references throughout to Bill 100, which I think was the first version of the Local Food Act. So yes, I think you're right.

Mr. Ernie Hardeman: Okay. I guess it's reasonable to assume, then, that the minister could have read your recommendations prior to preparation of the new bill.

Mr. Joseph Castrilli: Our model bill was released in February 2013, so I think it would have been possible for the government to do that, yes.

Mr. Ernie Hardeman: Okay. Thank you very much. The issue that has garnered a lot of discussion before and during the process here is setting targets and how you go about setting targets, and whether in fact at the end of that exercise, it would be trade-compliant. I think another presenter this afternoon mentioned that we have to be

very careful that we don't go beyond that trade compliance because we are also an exporting province and we want to continue doing that.

1720

Do you have some suggestions of whether the proposal in your bill would, in your opinion, be trade-compliant?

Mr. Joseph Castrilli: The primary concern that we saw with trade agreements was in the area of procurement, so we addressed that in section 12 of the model bill and we actually expanded upon that in our written submissions at pages 4 and 5. You'll note actually in the written submissions that there are, I believe, 15 US states that have passed legislation allowing purchasing preferences for in-state agricultural products. So it's clear that you can draft provincial or subnational legislation and still make it trade-compliant, and that's what we attempted to do in our bill.

Mr. Ernie Hardeman: In your opinion, when you do that—you can do it obviously with the procurement that the province does for itself, but could you pass a law that gives preferences to procurement of someone that the government is not involved with?

Mr. Joseph Castrilli: I think in our bill, we tried to focus primarily, as Bill 36 does, on public sector organizations, and so that was the scope of the focus.

Mr. Ernie Hardeman: Good. Thank you very much.

The Vice-Chair (Mr. Ted Chudleigh): Third party? Mr. Vanthof.

Mr. John Vanthof: Thank you very much for coming and for providing a legal perspective on local food because it is very important. Something that has bothered us from the start, when this legislation was proposed, is that there are terms like the minister "may" set goals, the minister "may" report. After all, we are developing legislation here. We're talking about laws, and it has always bothered us that I always see in brackets when I'm reading this: "or may not."

We're having trouble looking at a law that we don't really know what we're passing because the minister "may" set goals that we don't approve of around this table at all, and I would like to know your position on that and if we could strengthen the current act.

Mr. Joseph Castrilli: When we drafted the bill, we were cognizant of that concern. It's an issue in all environmental legislation in our experience, and so as much as possible we try to change the language from discretionary, the use of the word "may," to mandatory, the use of the word "shall." So we have done that wherever possible in the model bill. One of the places we did do it was in relation to the issue of the development of targets. You see that in a number of the sections in the early parts of the model bill, mostly in relation to the issue of having a time frame for actually developing targets.

There is no time frame in Bill 36, so one of the things we attempted to do, since we're not experts in what the targets in fact should be or even what the subject matter of the targets necessarily should be, was to set a time frame. We did a lot of research about what the issues

should be in the broader context of local food, but at the end of the day you actually have to—when you finally build a car, the car has to have an engine if it's going to go anywhere. You need to have some direction, and so a number of the provisions deal with mandatory obligations.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We appreciate the Canadian Environmental Law Association coming in and making a presentation. Thank you, sir.

Mr. Joseph Castrilli: All right. Thank you, Mr. Chairman.

ONTARIO COUNCIL OF HOSPITAL UNIONS/CUPE

The Vice-Chair (Mr. Ted Chudleigh): I'd now like to welcome the Ontario Council of Hospital Unions, Canadian Union of Public Employees, if they'd come forward. You'll have five minutes to make a presentation, followed by three minutes of questioning by each of the three parties. Welcome to the committee. If you would identify yourself for the purpose of Hansard, thank you very much.

Mr. Doug Allan: My name is Doug Allan. I'm research representative with the Canadian Union of Public Employees. Thank you for hearing us on behalf of 30,000 workers in hospitals and long-term-care homes, including many who work in foodservices in those facilities.

We believe the legislation is a step, but falls short. Public sector institutions should be a bulwark for fresh local food. Hospitals and long-term-care facilities, which people come to when they are most in need and at their weakest points, especially need fresh, nutritious food. We believe that these public institutions should be at the forefront of this movement, and the government should take steps to ensure that.

Unfortunately, the trend has been very much in the opposite direction. Ready-to-use food is creating a junk food culture, not just in our institutions but more broadly throughout society. Giant corporations have focused the bulk of their efforts on creating and marketing highly processed foods that are loaded in salt, fat, sugar and additives. The growing dominance of these foods has helped create an epidemic of obesity and ill health, in our view.

Unfortunately, ready-prepared, highly processed and frozen foods have come to our hospitals and our homes, shipped in over the highways from distant food factories. For the good of our society, this, we believe, must stop, and the public sector must play a lead role in changing this trend.

As the processed, globalized food culture grew, a major new social movement has grown up. Across the world, individuals are creating a fresh and nutritious food culture. Instead of accepting a diet of highly processed or frozen foods that are manufactured and transported over long distances, they are demanding fresh food that is made locally—local food that is made fresh.

Public sector organizations should help build the movement for fresh, nutritious and local food. With their size, public sector organizations can play a significant role to counter the corporate food force and as a key force for fresh, nutritious and local food. We think that should be the goal.

Public sector organizations should provide fresh, nutritious food that is prepared in local kitchens, preferably on-site. Public sector organizations should buy local foods wherever possible; foods shipped thousands of miles create carbon emissions, divert jobs from local economies and compromise the nutritional content of the food.

Public sector institutions should support local economies. Public sector dollars should be used to create jobs in local communities. Corporate food has created a globalized food system that has dramatically weakened local food infrastructure, a fact that we have discovered on our own.

Unfortunately, these principles are not being met. There has been a very sad decline in hospitals and in homes in terms of the quality of the food that they are able to serve. Indeed, in some cases, the food looks like it has been prepared in a dishwasher.

In long-term-care facilities, the situation is particularly depressing. One CUPE local president recounts how fresh vegetables were replaced by frozen vegetables in their home. Many of the residents in that home, whose friends and family are dying off, will never eat a fresh vegetable again in their lives, a very, very sad development.

In Kingston, we ran a campaign to get local and fresh food in the hospitals. We lost, unfortunately, but did create significant interest in the local community.

The Vice-Chair (Mr. Ted Chudleigh): One minute.

Mr. Doug Allan: One minute? Well, I'll just end by saying that now, with austerity, we are finding that we are actually going backwards. There has been a small movement towards fresh, local food in hospitals—Scarborough Hospital is a case in point, and the SickKids hospital—but these initiatives are now under threat. In fact, the Scarborough Hospital system is under direct threat right at this moment.

Andrea Horwath, in the Legislature, raised this threat. The Premier said, "Well, we're leaving this to locally determined decisions." Well, in our view, if this was a priority for the government, respectfully, we would say that it would happen. They control hospitals quite significantly, and they can do that.

We think we're going backwards, not forwards. We can't just have nice rhetoric and nice-sounding legislation; we actually have to take a direction and push forward very hard on this. Otherwise, our health and our future is at stake. We think that the public sector can play a very important role in this development.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, sir. We'll move to questioning, with the official opposition. Mr. Hardeman?

Mr. Ernie Hardeman: Thank you very much for your presentation. I think it's rather interesting that we

have a bill, the Local Food Act, which we all agree is the right thing to do—encouraging local food consumption—and the number one issue seems to be how we get our hospitals and our society that we control to do it. And yet, we're all nervous about putting in "shall do it" as opposed to "may do it." If it's the right thing to do and it's the best food there is, why do you think we're having trouble getting everybody onside to just willingly do it? Why should we have to legislate ourselves into something that we think needs to be done?

1730

Mr. Doug Allan: I think that's an excellent question. I do think our hospitals and our homes are under extreme, intense pressure to reduce costs. Our experience, not just over the last few years, but for quite a few years, is that fewer and fewer resources are going into the food, housekeeping and support services in the hospitals. The local health integration networks, which fund the hospitals and the long-term-care facilities, have \$300 million less budgeted this year than they did two years ago. There is intense pressure to cut costs.

I think this is a priority. Because it is a social decision that we can make collectively, we have to prioritize that, but we also have to find the money to do that. It's not a lot of money. We were making significant progress in Scarborough. That, it seems, is under serious threat at the moment with the deficit that that hospital suffers, but I think, with some money and some political will, we can make progress.

Mr. Ernie Hardeman: It would seem to me that if food—and I think, in everybody's mind, food is the number one priority for anyone, whether it's a patient or whether it's the person feeding the patient. If it's the number one priority, why is it so difficult to say, "Okay, that's where we're going to put our number one resources, to do that"?

The Vice-Chair (Mr. Ted Chudleigh): If we could have a very short response.

Mr. Doug Allan: A very short response? I think that in hospitals the number one priority is probably treating people who are acutely ill, and the other things get forgotten.

Mr. Ernie Hardeman: Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. The NDP?

Mr. Jonah Schein: Mr. Allan, thank you for coming in. I appreciate your presentation. Can you tell us a bit about the history of food in hospitals? I understand that the Scarborough Hospital has a fully functioning kitchen, which has not been operating until quite recently.

Mr. Doug Allan: Yes, it does.

For most of the previous century, food was made in the local hospitals. Through the period of the 1990s, our experience was that more and more food began to be manufactured, for want of a better word, in food factories, and then shipped to the hospital. The results were not satisfactory. There has been a movement—and I think our campaign helped play a role with that, I would say, perhaps immodestly—back toward fresh, local food, but it is a titanic struggle. I think even those small shoots that

we see in Scarborough and at the sick children's hospital are in serious jeopardy and our ability to move forward is in serious jeopardy. We've seen a very significant decline, both in our hospital housekeeping staff, which we think is associated with the rise in superbug infection in the hospitals that we found, and also in our food services staff.

We did a survey in 2010. We found a very strong connection between the sort of processed frozen food that's shipped into the hospital and bad reports of the quality of that food. We found, however, that in some of our smaller hospitals they still did have hospital kitchens that were functioning, and the reports were that the food was more satisfactory.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Government side? Mr. Crack.

Mr. Grant Crack: Thank you, Mr. Allan, for coming and for your excellent analogies of what the hospital unions are going through.

You talk about the public sector being at the forefront and taking a leadership role when it comes to procuring local food, but you also included "whenever possible." I guess my question to you would be if you could comment on that. From a government perspective, if we legislate targets in our public sector and broader public sector service, given the vastness of the province of Ontario and the availability of local produce in any given area, I think that's something that is a concern to us. How would you legislate, "wherever possible"? I guess that's my question.

Mr. Doug Allan: I'm not an expert in drafting legislation, so maybe I can come at this from a slightly different angle. One of the big barriers we found, for example in Kingston, when we did a campaign on local food, was that the hospital would just say, "Well, there's not the infrastructure to bring food in from the local area. It just doesn't exist anymore," and we're sort of stuck. Actually, I think they made a genuine attempt to bring in some local fresh food, at least to the cafeteria, and that was something. But they needed a backstop. They needed a policy and some backing from the government to actually create the economies of scale so that that the local food infrastructure could be created once again. Without that sort of collective action by government, which can require that infrastructure to be created, I think we're always going to be stuck at a market trend that has gone more global, and bringing in food from very distant locations.

Government can play a role in countervailing that and creating a different trend, but I think leaving it up to individual hospitals—Kingston General Hospital, for example, is a big, big institution, but it's not so big that it can, in itself, create a local food infrastructure in the Kingston-Frontenac area. So government policy and government money is going to be required in order to help create that and to change the trend and make the food fresh, local and nutritious once again.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, and we appreciate very much your coming in and sharing your views with the committee.

ONTARIO COLLABORATIVE GROUP ON HEALTHY EATING AND PHYSICAL ACTIVITY

The Vice-Chair (Mr. Ted Chudleigh): We'll now move to the Ontario Collaborative Group on Healthy Eating and Physical Activity. Welcome to the committee. You'll have five minutes for a presentation, and then we'll move to three minutes of questioning from each of the parties. Would you please identify yourself for Hansard.

Ms. Lynn Roblin: My name is Lynn Roblin. I am representing the Ontario Collaborative Group on Healthy Eating and Physical Activity.

The Vice-Chair (Mr. Ted Chudleigh): I'll give you a one-minute warning when you're coming to the end of your five minutes.

Ms. Lynn Roblin: Okay, that's great. Thank you.

Thank you for having me here this afternoon to present to you our thoughts on the Local Food Act. I'm here to present some background information on the Ontario Food and Nutrition Strategy, which is a plan for healthy food and farming here in Ontario, and how it can help with some of your decision-making around Bill 36.

I represent a group of not-for-profit academic organizations and academics who have been dedicated to looking at issues surrounding healthy eating, physical activity and the social determinants of health. For the past three years, we've had a food and nutrition design team actively looking at a food strategy that would be cross-government, involve civil society and private sector interests, and be a coordinated approach to food policy development, which Ontario has not had in the past.

We did have an opportunity to present this strategy to various ministries. Ten ministries attended a meeting we had earlier this year in February, and it was a great opportunity to show the possibilities where food does intersect with various ministries' work. The goals of this strategy are:

- to promote healthy eating and access to healthy food for all Ontarians;
- to reduce the burden of obesity and chronic disease on Ontarians and the health care system; and
- to strengthen the Ontario economy and the environment through a diverse, healthy and resilient food system.

We do have a draft document that lists a whole action plan with a number of priorities, which we've just put on the Sustain Ontario website. I'd encourage you to look at it there. I did not bring copies with me today, but there are a lot of really good examples of how we could help with this Local Food Act.

Some of the priorities that specifically relate to the Local Food Act are increasing access to safe, healthy, local and culturally acceptable foods, especially for vulnerable populations, through making sure healthy local foods are available in schools, daycares, workplaces and other public facilities, and through school nutrition programs. We're very pleased that the Ontario govern-

ment has supported student nutrition programs through the Healthy Kids Panel initiatives last week, with more support and 14 coordinators for food programs. That will really help, actually. We're hoping that will help access more local foods for the schools. We're also looking for more support for community access solutions, and you've heard about this already from presenters. There are opportunities locally with kitchen co-operatives, with local food bank programs, with cooking programs and things like that out there, and also community gardens.

1740

One of our other key priorities is increasing the utilization of Ontario food each year by government institutions. We've already heard some talk about some of those food procurement targets for the public sector, and I know some already exist. I'm from Halton region, and I know our cafeteria there has its own local food procurement target. So there are examples of what local food procurement targets exist in Ontario and in other jurisdictions.

Another point we raise is the importance of increasing the distribution and promotion of healthy and local foods. That would be supporting farmers and processors to deliver healthy products in demand, to market and promote local and sustainable foods, and to market, promote and support culinary tourism.

One of our key areas of concern today is increasing public understanding of healthy eating practices and skills for making healthy food choices through the life cycle. One of these is offering basic evidence-based food literacy through the curriculum to schoolchildren, but beyond that, to children in daycares, parents of young children and across the board. We really are lacking food skills and an awareness of what is a healthy food and certainly what is a local food, and how that contributes to our health, so lots of opportunities for that there.

One of our other priorities is ensuring that Ontario food products are preferred in all markets, so that we maintain an identifiable standard for Ontario food products. I believe we've already talked about the Foodland Ontario program, which is fabulous. We also want to ensure that Ontario is recognized as a leader in environmentally sustainable food production.

Some of the key asks we have are just to look at some of the specific wording, so instead of just "to increase awareness," we want "to increase awareness, access to and consumption of local food in Ontario," and an additional purpose, "(4) to support local food education, food literacy and food skills."

I've outlined some details to support that in the handout that I've passed around, so I hope that's helpful.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Coming from Halton, you got an extra 30 seconds.

We'll move to the NDP for questions.

Mr. Ernie Hardeman: I thought we had an impartial Chair.

The Vice-Chair (Mr. Ted Chudleigh): I am, with the exception of Halton.

Mr. Jonah Schein: I'm curious to hear further about your ideas around food literacy and schools. What would that look like?

Ms. Lynn Roblin: As the previous speaker mentioned, we do have Canada's Food Guide, which I proudly worked on, actually, with the federal government, and it's our primary education tool in schools. But where we're really lacking is food skills. When I was a child, in grades 7 and 8, we all got home ec. In grades 9, 10, 11 and 12, it was optional, but it was still there and it was available.

We do not have a mandatory food skills program here in Ontario, and we'd like to see that, particularly at the high school level, where there is so little opportunity for that. There is room in the curriculum for it. It needs to be creative, problem-solving; it probably has to be cross-curricular, but it needs to happen. We have kids graduating with math skills but not with food skills, so it's something that we're very interested in seeing happen.

Mr. Jonah Schein: In terms of student nutrition in the schools, how would you feel about setting local procurement targets attached to student nutrition?

Ms. Lynn Roblin: I think the student nutrition program guidelines already exist for the nutritional criteria of what's in those foods, and I think that could be expanded to include some targets for increasing local food use. I know that OMAF and Dietitians of Canada, which I am a member of, are already looking at a healthy fundraising program as a pilot, looking at linking local farmers and their foods and using those foods for fundraisers. There are all sorts of creative ways that local foods can be put into schools.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much.

We'll move to the government side: Mr. Colle.

Mr. Mike Colle: You remind me of back in the olden days. I was a high school health teacher, and what I would do is teach nutrition and Canada's Food Guide. I would tell them, "You're going to be tested three times this year, and I'm not going to warn you. What I'm going to ask you to do is bring your lunch to class, and then I'm going to grade each one of your lunches."

So every day they would ask, "Sir, is it today? Is it today? I've got a great lunch today." But I was just trying to teach and get them interested, and then I would get them to talk about nutrition at home. I would ask them: "What vegetables are you eating? Can you bring me a list of the vegetables that you eat around the house and how many times a week?"—getting them engaged and talking about good, healthy food at home. I think that's what you've been trying to do.

I was just wondering, how do we get people to increase their consumption of local foods? How do we do it? I've always said that one of the best deals in Canada is the price of food. I mean, nowhere in the world do we get the quality and price of food that we do in Canada. But how do we get people to consume local foods rather than imported foods, packaged foods—whatever it is? How do we do it?

Ms. Lynn Roblin: Well, I think we've already got a good example through our Foodland Ontario program, producing recipes, and I think we need those food skills to go with that. If people see the local foods—it's not just buying them; it's taking them home and doing something with them. We can start with educating kids on how to cook with some of these local foods, and they'll take that information back to the parents, as you've already indicated.

We just need more exposure to what those healthy foods would look like and how to prepare them.

Mr. Mike Colle: But really, a kid isn't going to look at a recipe. How do we get them excited? The former presenter talked about growing it, visiting, getting engaged. They want to touch these things. I just think, with your expertise—you've been at this—to give us more ideas on how we can get people excited.

I mean, we adults are always excited about food. We've got this great food truck explosion in Toronto. We've got street food, finally, after so many years of regulation where you had to eat those lousy, salty hot dogs all the time at street corners in Toronto.

We want to try to get people engaged. I think that young people are looking for that engagement, and we've got to find ways of sparking them.

Ms. Lynn Roblin: Yes, and I think you've already given some good examples. It starts with really young kids in daycare—right?—touching and feeling the food, experimenting with the food, helping to prepare food, helping to shop for the food—

Mr. Mike Colle: Yeah, preparing the food.

Ms. Lynn Roblin: —growing food. It goes all the way from daycares right up to high school and beyond with some of the adult groups we have in our community who haven't learned those food skills and where food comes from, and keeping that education going throughout the life cycle.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll go to the official opposition. Mrs. McKenna? No? Mr. Hardeman.

Mr. Ernie Hardeman: Thank you very much for your presentation.

Between the two acts—obviously we heard a bit of discussion about that this morning; there was an original act and then the new Premier and minister said she would introduce a strengthened act. Between the two acts, there was a long time when we didn't have to do much in this place because we were prorogued. So I had the opportunity to travel around the province and do round tables, knowing there was a new act coming, to discuss

the food act and what people thought should be in it and what we should do.

I don't think there was a single round table we held from one end of the province to the other where education wasn't the number one issue for everyone involved, as it is, I think, with your presentation. We've heard some alternative or different types of things we could do to further that education: to educate not only our children but their parents as to buying wholesome Ontario food for the table.

But all the things we've discussed, as it relates today—Foodland Ontario works wonderfully, but if it was doing the job, we wouldn't be here. So we need to do more. My suggestion is that we make it a mandatory course in the curriculum of our children in school: not something they may do if they wish to do it, but something they must do as a mandatory subject. What's your view on doing that?

Ms. Lynn Roblin: Well, what you've given an example of, Foodland Ontario, is a marketing program that's geared to the purchaser, whereas food skills development could be geared at the daycare or school-age population. What we're calling for in the Ontario Food and Nutrition Strategy—and I encourage you to look at that as a framework for your policy decisions—is that it's a comprehensive approach and it's multi-pronged. You need all these things to be working together to have an impact. As far as local food is concerned, it really does need to cross a few different areas.

Mr. Ernie Hardeman: Now, when you do your program, is it predicated on healthy eating or local food eating, or is that the same, in your opinion?

Ms. Lynn Roblin: Both. It's healthy and local food.

Mr. Ernie Hardeman: They're both the same.

Ms. Lynn Roblin: Yes, they're both part of it. If you go into the strategy and look at the language, it's healthy and local food.

Mr. Ernie Hardeman: Thank you very much for your presentation today, and thank you, Mr. Chairman. Before you—I mean, I'll stop. Well, maybe not. Maybe I'll just keep going until breakfast.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. That concludes our deputations for today. I'd remind the committee that we meet next on October 22. That's two Tuesdays out. We'll meet at approximately 4 p.m. for further public hearings.

Thank you very much. I'll try to see if I can get some apple blossoms. Would you like some apple blossoms? They're only in our caucus room.

The committee adjourned at 1750.

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Lundi 21 octobre 2013

Standing Committee on Social Policy

Oversight of pharmaceutical
companies

Comité permanent de la politique sociale

La surveillance, le contrôle et la
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 21 October 2013

Lundi 21 octobre 2013

*The committee met at 1405 in committee room 1.*OVERSIGHT OF PHARMACEUTICAL
COMPANIES

The Chair (Mr. Ernie Hardeman): We'll call the Standing Committee on Social Policy to order for the committee hearing for October 21, on the study relating to the oversight, monitoring and regulation of non-accredited pharmaceutical companies. I welcome everyone.

Before we hear our presenter today, I think you have a motion, Ms. Jaczek.

Ms. Helena Jaczek: Yes. I move that Rod Jackson replaces Jane McKenna on the subcommittee for committee business.

The Chair (Mr. Ernie Hardeman): You've heard the motion. All those in favour? Opposed? I didn't hear any nays, so I'm going to take it as carried.

HEALTH CANADA

The Chair (Mr. Ernie Hardeman): For delegations today, we have Health Canada here: Dr. Supriya Sharma.

We thank you very much for coming today. We'll give you 20 minutes for an opening statement—you can use any or all of that—and then we will have questions from the three parties. We will start with the third party in this round, and hopefully address this all in about an hour and a half, if we can get it all in.

We have an oath; we're doing all of the hearings under oath. The Clerk will issue the oath or the affirmation.

The Clerk of the Committee (Mr. William Short): Dr. Sharma, if you could just raise your right hand. Do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Dr. Supriya Sharma: I do.

The Chair (Mr. Ernie Hardeman): With that, the floor is yours.

Interruption.

Dr. Supriya Sharma: I thought there was—did you have housekeeping? Done? Okay. Thank you very much.

Good afternoon, Mr. Chair and members of the committee. I would like to thank you for inviting me to appear today. I look forward to outlining the actions

Health Canada has taken relating to the important oncology medication issue that the committee is studying.

Firstly, I thought I'd share a bit of my background with you. I'm currently the senior medical adviser of the health products and food branch in Health Canada. I'll speak in more detail about the role of the organization a bit later, but overall it's the authority that is responsible, among other things, for regulating the manufacture and sale of pharmaceuticals in Canada.

I'm trained as a pediatrician. I earned my MD from the University of Ottawa, and completed my pediatrics residency in Calgary and in Australia. I then earned a hematology/oncology research fellowship at the Hospital for Sick Children and the Toronto General Hospital. I also have a master's degree in public health from Harvard University. Following my master's, I did a project writing a Harvard business case on how large-scale health care institutions incorporate patient safety initiatives into their organizations. I've worked at Health Canada since 2002, in a variety of management positions.

Mr. Chair, I'd like to share my initial personal reaction when I first heard about the reported underdosing of chemotherapy drugs. First and foremost, I thought of my own friends and family. Patients and loved ones always invest tremendous trust in the quality of care being received. This is even more so in the case of potentially life-threatening diseases such as cancer.

Like so many Canadians, I too have had people very dear to me who have suffered from cancer and have relied on chemotherapy drugs for life-saving treatment, so my feelings were no different than those of concerned family members that were reported in the media or conveyed to the committee. I was worried and uncertain as to whether my loved ones had received lower-than-intended doses and, if so, what it would have meant to their overall care and prognoses.

As a trained health care professional, my thoughts also went out to the first-line health care providers who were treating the affected patients. We're all in this field to help people. Having studied medication errors and incidents, and how health care institutions deal with patient safety issues, I'm well aware of how devastating it can be for health care providers to learn that anything they might have done may have adversely affected patient outcomes.

Then I thought of the mandate of Health Canada, and what role we would need to play in determining what had

happened, as well as what role we could best play in achieving a solution to the problem.

1410

Health Canada, and more specifically, the health products and food branch, was contacted by the Ontario Ministry of Health and Long-Term Care on the evening of April 1, 2013, and informed of the public communication that was to go out regarding the reported underdosing of certain chemotherapy drugs.

Mr. Chair, from the moment we first heard about the incident from the ministry, I and my colleagues have taken the situation very seriously. Working with provincial and territorial partners, our actions have taken two tracks:

—in the short term, identifying the circumstances and practices at the Marchese Hospital Solutions facility where the underdosing was reported to have occurred; and,

—in the longer term, understanding the extent and scope of these compounding-like activities across Canada and working toward longer-term solutions to provide clarity regarding appropriate safety oversight.

Together with colleagues from the Ontario College of Pharmacists, Health Canada sent inspectors into the Marchese facility for a fact-finding visit to better understand what activities were taking place in the facility and under what oversight. Letters outlining a series of questions based upon what we found were then sent to Marchese under the joint signature of Health Canada, the Ontario Ministry of Health and Long-Term Care, and the Ontario College of Pharmacists. The responses to those letters and the materials provided further delineated the details of the processes and procedures of procurement, as well as the preparation of the medications supplied to hospitals.

During that same time period, Dr. Jake Thiessen was appointed by the Ontario Minister of Health to provide an independent assessment of the circumstances surrounding the situation. Health Canada was pleased to sit as a member of the working group brought together by the ministry to share information and to support his painstaking work.

As the facts surrounding the underdosing incident in Ontario emerged, Health Canada and all provincial and territorial regulators developed a more detailed understanding of how the practice of pharmacy has changed and evolved to adapt to a new drug preparation and purchasing model. We were able to clarify the complexity and diversity of practices that existed even within a single organization.

Mr. Chair, our understanding and regulation of traditional drug compounding has been premised on the issuance of a prescription or a hospital order by a health care practitioner for the delivery of a single drug to a single patient. Indeed, it is for this reason that compounding as traditionally understood has been covered by provincial and territorial physician and pharmacy regulations. It has been explicitly exempted from the relevant

federal regulations, which have focused on drug manufacturing processes.

Today, compounding-like activities are being conducted in dedicated facilities by third parties, outside a health care setting and for many patients at once, often without a specific prescription. As a practical matter, it has come to look like a kind of hybrid of compounding and manufacturing. This type of activity challenges existing federal and PT regulatory definitions and regimes, which were not explicitly designed to capture these types of activities in a manner that is proportional to the potential risk to patients.

While we were working collaboratively to assess longer-term approaches to ensure appropriate oversight of these activities, we also felt that Canadians needed to know how existing frameworks were being applied to protect their safety. To this end, on April 19, 2013, Health Canada issued an interim direction to facilities undertaking admixing/compounding activities and outlined the conditions under which they could be allowed to continue providing services:

(1) They are done within a hospital, meeting provincial regulatory requirements;

(2) They are done outside a hospital, as a service under the supervision of a provincially licensed pharmacist; or

(3) They are done in a manner that meets the licensing and manufacturing requirements of the federal Food and Drugs Act and regulations.

Canadians could be reassured that organizations following these directions would have the active oversight in place to help ensure the safety and effectiveness of health products prepared in this way. As a follow-up to the issuance of the directive, we surveyed all companies that were performing compounding/admixing activities and asked them to report to us whether or not they were conducting the activities, and if so, to declare what category they fell under.

On the same day, the Ontario Minister of Health announced new regulations to allow the Ontario College of Pharmacists to inspect drug preparation premises in Ontario and to require hospitals to purchase products only from facilities that had passed such inspections.

With that level of certainty in place in Ontario and across Canada, Health Canada then took on a leadership role in facilitating the development of a longer-term solution. We brought together provinces and territories through an assistant deputy minister-level task group. This group focused first on understanding the extent and scope of these activities in the various jurisdictions.

Provinces and territories collected information on facilities undertaking these activities, their oversight and on the drivers for the expansion of this model. The information collected showed a variety of practices and oversight frameworks that are in place.

The information from the provinces and territories augmented Health Canada's outreach to companies. Overall, companies were identified that were conducting compounding/admixing services, the vast majority of which are in Ontario and Quebec.

In parallel, Health Canada reached out to the Council of Pharmacy Registrars of Canada. This group, along with representatives of the National Association of Pharmacy Regulatory Authorities, provided a great deal of information on regulatory oversight, capacity and pharmacy practices both at the hospital and the community level in the provinces and territories.

In broad terms, the task groups supported a national approach to oversight, as well as a strong desire to help move a framework forward. Caution was expressed, however, about what that solution should be, and that it be implemented in a measured, methodical way, given the complexity of existing practices across the country. We were cautioned against moving too rapidly towards a solution, without fully examining all the intended and unintended consequences. We do not, for example, want to find ourselves in a drug shortage situation because new regulations require a significant retooling of existing facilities.

In fact, it was the collaboration at these tables that provided the necessary information to fully understand the scope of practice at the national level. As Dr. Thiessen has reported to the committee, he felt that the manner in which all parties came together around the circumstances was exemplary.

What emerged from these discussions was a lack of clarity regarding the actual activities being undertaken by companies and the need to more clearly delineate what would most appropriately be regulated at the provincial/territorial level as opposed to at the federal level.

To this end, a subgroup was brought together by Health Canada that included representatives from the provincial/territorial committee, three representatives appointed by the National Association of Pharmacy Regulatory Authorities, the Canadian Society of Hospital Pharmacists, the Canadian Pharmacists Association and Accreditation Canada. This group met over the summer and parsed out the necessary detail to better map out the practices of compounding, manufacturing, as well as more clearly define this new practice of compounding-like activities.

Mr. Chair, as our Minister of Health has said, Health Canada accepts Dr. Thiessen's findings. These compounding-like activities require more effective regulatory oversight. Health Canada will play a leadership role in the oversight of these activities. Indeed, such work is really just a continuation of the leadership role we have taken since first learning of the reported under-dosing in Ontario last spring.

However, as mentioned previously, we have learned throughout this process that there is a significant variation in approach and capacity across Canadian provinces and territories to oversee these activities. Therefore, it's very important that we continue our collaborative, thoughtful approach to the issue to avoid unintended consequences, including impacts on the supply of needed medications for Canadians. Dr. Thiessen's report of what occurred here in Ontario is a pillar of this work. At the

federal level, we need to find a way to give it practical expression in a way that respects the varying provincial and territorial approaches.

Mr. Chair, although we are still assessing how best to implement a fair, reasonable approach to oversight that improves patient safety across the country, we feel that we have a fairly clear understanding of where we will be heading. Coming out of the collaborative efforts to date, we feel that we have come to ground on a good working definition for these new activities. The definitions and associated criteria provide precision to distinguish the type of activity being conducted, by whom, according to what standard or standards and to what end. On this basis, regulatory oversight can be more clearly applied.

From a federal perspective, we would continue to exempt "traditional" compounding from federal requirements, and focus our attention on those other activities that appear to be a hybrid between compounding and manufacturing. Such an approach would continue to balance the complementary roles of Health Canada for the safety, quality and efficacy of drugs with the benefits gained from the knowledge and expertise of health care professionals in an established patient-practitioner relationship.

Given the unique nature of these activities, Health Canada will be looking to develop a risk-based approach that focuses on the safety and quality of these activities and products. We will also be looking to integrate other key elements in this approach, including labelling and reporting requirements.

We will continue our work in this regard and hope to have something to share more broadly with Ontario and all provinces and territories in the coming months.

Mr. Chair, I would again like to thank you for listening to my presentation, and I would now be happy to take questions.

1420

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. With that, we'll start with the questions from the third party. Ms. Gélinas.

M^{me} France Gélinas: Thank you for being here. You have put together this committee. You're trying to move forward in a way that does more good than harm. Your example clearly shows we wouldn't want to put something forward that would lead to drug shortages or whatever else. You're looking at a hybrid between compounding and manufacturing, which is basically—the work that Marchese had done could be defined in that way. Did you look at all at the group purchasing organizations, which also had a role to play in bringing the diluted chemo drugs?

Dr. Supriya Sharma: Well, certainly we've been following the work of the committee. In our fact-finding discussions with Marchese, we had to go through and sort out what their business model was like. That's when we had more information in terms of the role that the group purchasing organization plays.

Certainly in the regulation of the actual products, the group purchasing organization is in a unique position

because they don't actually prepare or take possession or fabricate or treat the actual products themselves; they're actually an intermediary in the contracting process. So what we're focusing on are the actual activities near the products, the premises, the people, the processes that are in place, and we haven't been specifically looking at any particular oversight of the group purchasing organizations as such because of the nature of their place in the system.

M^{me} France Gélinas: After Dr. Thiessen finished his report, he came and presented to the committee. One of the questions I asked him was basically along the same lines of what I just asked you as to the value oversight. We realize that because pharmacists, pharmacies have oversight, because a hospital has oversight, it increases the quality of drugs, as well as everything else that they do. But such oversight does not exist for the group purchasing organizations, although they kind of were at the genesis of why. Had their request for proposal said that this preparation had to be concentration-specific, none of us would have ever come here, 1,000 Ontarians wouldn't have had to live through what they lived through. So to completely ignore them was not the way to go.

Dr. Thiessen, in his testimony in front of this committee, sort of said yes, it was something that should have gone. He said, "The idea of some kind of an infrastructure—perhaps government infrastructure, even national infrastructure—which would lead to some oversight of" the group purchasing organization "is something that is worth considering." I'm quoting Dr. Thiessen. Because those group purchasing organizations don't only work in Ontario—in this particular case, some of the drugs were shipped to New Brunswick—he saw a role for the federal government to play. I wanted to have your feel as to, is this feasible or unthinkable?

Dr. Supriya Sharma: Of course, we're following the work of the committee very closely, and I read the same comments in terms of the testimony. We sit on the membership of the implementation working group, and that was brought together by the Ministry of Health in Ontario to look at Dr. Thiessen's recommendations. Dr. Thiessen did direct a number of his recommendations towards the group purchasing organization, but as he said in front of committee, this was something that didn't actually make it into his report. Through that group and our work with Ontario, we're willing to look at the issue as a separate issue in addition to the comments that Dr. Thiessen has made. We haven't turned our minds to that at this point in time, but we're willing to take a look at that as an option.

M^{me} France Gélinas: And that would be done at the level of the same committee that you make reference to in the presentation you've just given us today?

Dr. Supriya Sharma: There are a number of different committees. The one that I was just referring to is called the implementation working group. We used to have a group that was there as a working group to share information at the time that the issue came about and to

support Dr. Thiessen's work. That committee has been sort of sunsetted, and now a separate group has been brought together to look at the actual report, and then moving forward on implementing the recommendations. That's probably a good venue at least to start the discussions around a broader look at the group purchasing organizations.

M^{me} France Gélinas: How will we find out what was decided from that group if it's decided to leave things as is? If there's no action, specifically for group purchasing organizations, how do we find out the reason why and basically what went on at your committee?

Dr. Supriya Sharma: My understanding, and I think this is probably a question better placed at the ministry, is that there will be at least a report or something else that will come out of that group that we're working with to be able to show progress in terms of the recommendations. I think that's probably the best place to have any sort of report coming out from the work of that group that's been brought together.

M^{me} France Gélinas: Okay. I would ask the Clerk to follow up—when you do have a final report, if it could be shared with this committee.

Dr. Supriya Sharma: Absolutely.

M^{me} France Gélinas: My second series of questions: Your committee does its work, does the implementation, and we put in some kind of an oversight structure for the hybrid between compounding and manufacturing. Looking back, it seems like that was an issue that had been raised quite some time ago. Copies of emails were shared with us that showed that as early as 2001 and 2003, this area of new work had been identified that fell between two areas of oversight, where Health Canada did manufacturing and Ontario, in this case, did the oversight. How could you explain to the committee why this work was not done sooner? Everybody knew that that hybrid, compounding and manufacturing, was happening in more than one province, in quite a few facilities, and it was not done before.

Dr. Supriya Sharma: It's a really good question. As Dr. Thiessen has said, when we're hearing about how the overall situation has been characterized, people have been referring to things like a gap. In reality, there's no gap. For me, a gap is a space between two sets of regulations, so there's a place where an activity is not covered off at all. I don't think that was the case. If you look at the regulations that are in place at the provincial/territorial level of compounding, those were in place. Then we have regulations at the manufacturing side of things. There was no light in between those. There was, I think, a need for clarity to say, "Given how you're structuring your activities, you would fall under one or the other."

It actually goes back to even before 2000. Back in 1997 was when you first started having discussions around compounding and manufacturing and being able to tell the difference between the two of those. We had workshops and we had discussions, and that actually gave rise to our first policy, which is now policy 51, talking about compounding and manufacturing. I know

the committee has referred to that policy before. So that was first published in 2000. Then, continuing practices—they kept evolving, and we brought people together again, because there was a need for more clarity and more guidance as to how one would fall into one or the other. So that guidance was updated in 2004, and then it was updated again in 2009.

Throughout this period, we've been aware that there have been changes. What we've been doing is strengthening our documentation to be able to give guidance to industry to say, "Depending on how you're structuring your business"—and it really does depend on how you're structuring your business—"you would fall into one category or another." We were actually in the process of revising that document again when this situation came to pass. And if you look at that document, under compounding alone, there are I believe 14 different categories of things that you need to consider that would help put you in one category or another.

So it has been a long time coming, but we have been trying to give as much guidance as possible. To a large extent, people and companies have been following that guidance, and then have been electing to go into one category or another, or not. Frankly, we've had companies that have come to us and sought guidance, and we've outlined, "If you follow a certain business plan, you would be regulated by the province, and these are the regulations you would have to abide by. And if you are not, then you would fall under manufacturing, and this is what you would do under Health Canada's regulations." Some companies have either decided not to go into that line of business, or they've structured themselves either as manufacturers or as compounders and have gone into business. This was, I think, a different situation.

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M^{me} France Gélinas: Okay. So do you think that through the implementation committee this will continue, as in they will have to basically do their homework and identify themselves as falling within one oversight or the other, or do you foresee new categories of oversight being created?

Dr. Supriya Sharma: We're looking at putting together a new category. I think we're looking at leaving the definition of manufacturing as it is. Certainly, it's a global industry that we deal with, and we have other international standards and requirements and harmonization initiatives that we're party to, so disturbing that or changing that would have, I think, a bigger impact.

Then we're looking at strengthening what we're putting in the traditional compounding category. That has been interesting as well, because different provinces have different definitions of compounding. So we're looking at harmonizing that definition and having one broad, overarching definition of compounding.

Then we're looking at what is falling in between and looking at creating a new category, and we're still working through what that will be called. Our working definition is called commercial compounding-manufacturing, and the pivot point in terms of defining those

activities really is the patient-practitioner relationship. We're looking at the evidence of a prescription or a hospital order as defining that as a pivot point, and then we are looking at expanding that definition to make sure that we are giving as much clarity to it as possible.

But also, we don't want to then create another category that would then be used to potentially circumvent other regulations. For example, if we have manufacturing regulations in place, we don't want people to then go into another category that potentially has a slightly different or potentially lighter regulatory touch to avoid going through the full set of manufacturing standards and regulations. The developing of that middle category is exactly what we're doing now, so looking at, as we said, products, personnel, premises, procedures, labelling, reporting, standards. All of that work is ongoing.

M^{me} France Gélinas: Would you see this falling under the federal government, this new category?

Dr. Supriya Sharma: Yes.

M^{me} France Gélinas: Okay. Thank you. It has been some time now since we found out about the diluted chemo drugs. I can see that you have spent a whole lot of time, brainpower, effort and energy trying to move us forward. Do you feel confident that this new category, as you call it, would be able to catch something like this and prevent it from happening? The people who have received this awful phone call telling them, "By the way, you received the diluted chemo drug" are also following what this committee is doing. They see a group of hospitals wanting to do the right thing, with 11 pharmacists reviewing a request for proposals that all missed the fact that this drug had to be concentration-specific. Medbuy missed that. It then went to Marchese, which had four fully licensed pharmacists who compounded the drugs and completely missed that this drug had to be concentration-specific. It then went back to pharmacists in cancer treatment centres, who know those drugs and who deal with them and who are oncology pharmacists, who missed the fact that this drug had to be concentration-specific. How do we assure those people that the good work that you're doing will prevent this from happening?

Dr. Supriya Sharma: In my opening remarks I talked a bit about personally having the same thoughts as the patients and the families. My family is from southern Ontario, and yesterday I saw my cousin who had gone through chemotherapy in this past year in Ontario and had cyclophosphamide. So I know exactly how they felt when they actually got the news. I have to say that bringing Dr. Thiessen in to take a look at the issue—I have a great deal of personal and professional respect for him, and he outlined a number of recommendations specific to this situation. We're all working together to move ahead on those recommendations.

When we're looking at the Health Canada portion of it, in terms of licensing these facilities, of course we're looking at the situation that happened, but we're also building a system not only for today but for tomorrow as well. When we had the SARS outbreak, I was part of the group that did the lessons learned, and the line that we

were talking about was that the next SARS is not going to be SARS.

I have the utmost confidence that when we're looking at the situation, when we're working with people, that we're looking at everything that has happened in this case and we are looking at the regulatory framework set in place, how products are used and everything that we've learned from this situation to make sure that when we're putting in oversight, we are putting in patient safety measures that will ensure that it doesn't happen again.

The health system is a complicated system. I could spend the entire hour and a half going on just about the regulations at the federal level, but those are details, and, frankly, patients don't need to know those details. Families don't really care about details. That's what they pay us to look for and look at and go through, and that's what we're doing. We're looking at what we have and what we can put in place to make sure that the appropriate oversight exists.

There still is that aspect of patient care, health care professional activities, that also has to come in, and that's a very personalized sort of activity. We need to take account of that as well.

If you'll indulge me, my history is in patient safety and medication errors and incidents. James Reason published a model back in 2000 called the Swiss cheese model of medical error. Basically, I've heard comments at the committee saying that every time you put a layer in, you're introducing an aspect of error. But what the model actually says is that, absolutely, each layer has a hole in it or may have multiple holes in it, but each layer also has the ability to be a defence, and a defence that would stop an error from actually going through. So when you get a catastrophic error or something that actually reaches patients, it's because all the holes line up, and what you try to do in a system is make sure that you have as few holes as possible, they're as small as possible, and that when you're putting in layers, each of them can act as a defence, a place or something that can get caught. That's not just oversight, but I think that's all the way through the system.

So we're working with our partners on the federal aspect. We're working with our National Association of Pharmacy Regulatory Authorities. They're putting standards in place for community and hospital pharmacies. We're working with our colleagues in the Canadian Society of Hospital Pharmacists. Wherever this activity is taking place, whether it's something that is regulated federally or is something that is regulated provincially—that we have the same standards in place for the same types of activities that have the same levels of risks associated with them.

M^{me} France Gélinas: I'll save my time.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. The government side: Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair, and thank you, Dr. Sharma, for your presentation.

I would like to have a little bit more clarification on a couple of points, and it's picking up a little bit on my

colleague's questions. On April 19, 2013, Health Canada issued an interim direction made up of three requirements: that what we have called admixing here basically be done within a hospital, meeting provincial regulatory requirements; done, outside a hospital, as a service under the supervision of a provincially licensed pharmacist—which Marchese Solutions did have; and three, done in a manner that meets the licensing and manufacturing requirements of the federal Food and Drugs Act.

So my question is, how would these conditions actually prevent what happened in this situation, which essentially was a miscommunication related to the need for a concentration-specific product? I'm missing how this would have prevented the situation.

Dr. Supriya Sharma: I think the interim direction was really designed to say that this is actually what is the situation now, in that if you're providing these services, you should have appropriate oversight. That interim direction was in concert with the activities that Ontario had put forward. So Ontario really stepped up to say that they were putting in measures so that drug preparation premises could be inspected and they would have that oversight.

In this case, if we're speaking specifically from Marchese, we would have that pharmacist there and they would be supervising the activities, but that was also coupled with the fact that you would have inspectors from the Ontario College of Pharmacists that would go and inspect the facilities.

Speaking specifically with the incident, I do have to defer to Dr. Thiessen's report. He really pointed out, as you've said, the four areas where the error sort of could have been picked up, and I do acknowledge that the oversight part of it wasn't directly impacting that specific situation, which is why, when he did his report, there were 12 recommendations. The one that was directed at Health Canada in terms of the licensing was just one of those.

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In speaking with us, he basically has said that he wanted to address the issue, but that from his public service side, he wanted to make sure that other aspects of what he had seen that he felt that he wanted to comment on—he wanted to make sure that he did incorporate that into his report, and I think that's what he did with the recommendation for Health Canada.

Ms. Helena Jaczek: Thank you. Health Canada has obviously been very busy since this incident occurred, and you've been looking nationally at companies that are involved with compounding or admixing services, the vast majority of which are in Ontario or Quebec, as you've said. Did you get any sense of how many hospitals are actually acquiring their chemotherapeutic admixed compounds from these companies? Has this now become basically the norm? How big is this across the country?

Dr. Supriya Sharma: We did ask in general terms about the business model and we did get information from provinces and territories to talk a bit about scope,

and it really is very variable. There are some provinces where they have either very limited types of products that they outsource or very limited companies that they deal with, and then different provinces have taken different approaches.

For example, in British Columbia, there's a centre called the Lower Mainland Consolidation centre. That is a free-standing structure where three health regions have come together and have put up a facility for centralized pharmacy admixing types of activities and other pharmacy activities. It looks very much like a Marchese would look or another company would look, but it is fully owned by the hospitals. That's one model, for example.

In Alberta, they actually have a special designation for what they call compounding and repackaging pharmacies, so the one facility that fell into the category that we were serving that was in Alberta actually has a licence with the Alberta provincial government.

In Quebec, we certainly have seen that there is a fair amount of outsourcing that's happening. The Ordre des pharmaciens du Québec has standards, both for sterile and non-sterile admixing, that they inspect against.

So it's really variable, and I have to say, there's also variability among the sizes of hospitals as well. We have those in broad brush strokes.

The most detailed look, I think, was the survey that was done by the Ontario Hospital Association, and I believe that's been provided to the committee. That really gives the best picture for Ontario specifically.

Ms. Helena Jaczek: As an example, that facility in the Lower Mainland doesn't have any kind of licence from Health Canada. They are provincially monitored in some fashion.

Dr. Supriya Sharma: That's right. They actually fall under the hospital. They're fully owned by the hospital, and the registrars in British Columbia have the authority to inspect hospital pharmacies in practice.

Now, if they were preparing—for example, if they're using narcotics or controlled substances and they're doing that in a non-patient-specific manner, there would be a role for Health Canada from that aspect. But currently, no, we don't have oversight over that facility because of how the province and territory regulate them.

Ms. Helena Jaczek: It's your expectation as a physician, perhaps, that an inspection by a college of pharmacists, going into one of these premises that is admixing compounds, would talk about admixtures that can be administered to multiple patients. You would expect that to be part and parcel of the inspection, that that be a special category.

Dr. Supriya Sharma: Yes. Definitely, in terms of whether the inspection is happening at a federal level or at a provincial level, you look at the spectrum of activities that are taking place and then make sure that the appropriate standards are being applied.

In the case of both sterile and non-sterile admixtures, it would either be the USP 797 and 795; I know those standards have been discussed here at the committee.

Those are the ones that are the most commonly applied and then expanded, so each province may have additional requirements where they may bring in other elements that they would be looking at as well in terms of recording and record keeping etc., and then they would apply those standards. But absolutely, it would be something that would be inspected against.

Ms. Helena Jaczek: So you would expect, if we hadn't had this situation at Marchese, with the type of inspection that would be done through the College of Pharmacists, that they would go in and they would specifically talk about some of these types of admixtures and really drill down how you are going to prepare it, with the volume versus the therapeutic agent being specifically talked about.

Dr. Supriya Sharma: Yes, and beyond that, to the point of your laminar airflow through the facilities, how you're labelling even your intermediaries. So if you're doing admixing, there are some requirements on what the final product would look like and what that label would say. But even along the process, the requirements on which vials are there, who signs off on them—it's a very detailed set of standards that they would be inspecting against.

Ms. Helena Jaczek: Okay. Just another thing from your presentation: You talk about, "From a federal perspective, we would continue to exempt 'traditional' compounding." What exactly do you mean by "'traditional' compounding"?

Dr. Supriya Sharma: And you'll notice that "traditional" is in quotes in there, because part of the discussion that we've had is, really, what is traditional compounding? As I had mentioned, compounding as a definition can be different from province to province. The National Association of Pharmacy Regulatory Authorities has actually put together a national definition and people can choose to adopt that.

But when we think of traditional compounding, it really is making a specific dose for a specific patient to meet a specific need. And there are some other circumstances around that. So, for example, it can't duplicate a commercially available product. We don't want people compounding products that should otherwise be—you know, have a drug product identification number, unless it's a shortage situation. There are other parameters in terms of patient safety etc., but really it focuses on: Somebody is coming in and there is a product that I need to provide to meet those patient needs. It is not otherwise available, so I need to compound for that specific person.

Ms. Helena Jaczek: So would you say that, from your perspective, with all the work that Health Canada has been doing subsequent to this very unfortunate event, you've had good co-operation with all the provinces, that the dialogue has really been very, very helpful, and you see your way forward to national oversight, with agreement with provinces as appropriate, that will really drill down and make sure something like this will not happen in the future?

Dr. Supriya Sharma: Absolutely. I was looking back, in preparation for the committee, through the notes, and

as I was looking back, I thought, this is actually a model I would replicate in terms of how people came together, how we worked collaboratively, how we were on teleconferences at 10 o'clock at night. Maybe I would move those times around a little bit, but certainly we worked very, very well together, and brought people together, I think, around key issues. We had high-level discussions, and then, when we found we got to a place where we needed more technical discussion and needed to drill down deeper, we brought a subgroup together.

We're still in that process, so I think I can't declare victory at this point in time, but I think we really have accomplished a lot in a short period of time, and we do have a path forward that will get us to a place where we will hopefully have a proposal fairly shortly. Then, of course, it will have to go out for consultation and will benefit from the input of all the stakeholders in finalizing that and then implementing it.

Ms. Helena Jaczek: Were you aware of what has been called this grey area of lack of oversight prior to this incident?

Dr. Supriya Sharma: I was aware, as I mentioned, of needing to sort out what is compounding and what is manufacturing. In terms of the terminology that's been used around this, it wasn't something that I was familiar with. Because I wasn't at, of course, all the meetings going back through the years, I went back specifically looking for whether there was a place where somebody said, where there was a group that said, "We think that federally you need to create a new category because there is some confusion and it should be separate and you should regulate that." That wasn't the case. We didn't see that in the communications. We did see that there was a need, as I said, for more clarity around what is compounding, what is manufacturing, and there was discussion around admixing as an activity and where it should appropriately fall.

So in that situation, yes, I think there was some discussion about what is now being referred to as something different in the press and by other people. But, no, it wasn't the way that I think it's been characterized.

Ms. Helena Jaczek: Had any other compounders, like Marchese, approached Health Canada prior to this event? Did you find any correspondence from other companies providing this service?

Dr. Supriya Sharma: Yes, we have. As recently as March, we had another company that came in and provided a detailed presentation, and we walked through what would be the different requirements under the different regulatory frameworks. That company actually decided to wait and said that instead of going one way or the other, they would wait till a proposal was put forth and a separate category was created before they would come into business. Other companies have made those decisions. We've had companies that have come in and asked questions and they are accredited pharmacies, and the activities they were doing—they were regulated under provinces and territories. There's been a mix, but certainly we've had companies come to us.

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Ms. Helena Jaczek: Thank you. We'll reserve our time.

The Chair (Mr. Ernie Hardeman): Thank you. The official opposition: Ms. McKenna.

Mrs. Jane McKenna: Thank you so much for coming. I have a couple of questions. There are so many papers that we've looked at, but anyway, just the stack here: It came to our attention, and it was in the paper in the London press, that it goes back as far as 1997 and that these companies that prepare mixtures and compounds of drugs weren't being inspected by either federal officials who inspected drug manufacturers or provincial regulators who supervised drug dispensary. And then there's a quote back here by Ms. Matthews saying that she admitted there was a grey area in oversight that had been eliminated. "It became clear pretty quickly that we needed to ensure that drugs are purchased from an accredited facility. We could have waited (for Thiessen's report)," which obviously was before that, "but I just did not want to wait," she was saying.

I guess my question to you is that if so many people knew there was a grey area, because clearly there is—I mean, we have documentation of people saying it, from the minister down to—you know, for 15 years they've been asking this question. Why is it that it's so grey, even with people like yourself, who are in the situation yourself? I'm so confused with that, that it's so grey and we're still talking about how grey it is when there are so many people, including the minister, who realized there was a problem.

Dr. Supriya Sharma: Again, I don't think it was a gap. The question is, where would these activities fall? So if you look at drug manufacturing—taking a molecule and making it into a tablet or a capsule or whatever it is—there's a whole spectrum of activities, everything from using sterile processes to making the intravenous fluids it goes through to making an ointment, potentially, and there are risks associated with it.

If we're looking at admixing, it's at that lower end. You're taking approved products that have quality oversight and safety oversight, they're approved by Health Canada and you're mixing them together, a relatively low-risk activity. If you look at it from the pharmacy side of things—I don't know if we have a pharmacist in the room who'll call me out. Remington is the bible of pharmacy practice and when it talks about admixing, it talks about it as being one of the highest-risk activities that take place. So that's in the spectrum.

There are these activities and if you look at where they're taking place, they're taking place—if you're just looking at the activities, they're taking place in community pharmacies, in hospital pharmacies, at the bedside and in private facilities.

I think the question is—it's an activity and it's changed and it's evolved and it's taking place in a number of different places. Depending on how you structure your business or your practice, you could fall under one regime or another. I think that's where the con-

fusion was lying. It wasn't that there was a zone where you should be in business and no one should be seeing you. It's that you need to come under one umbrella or another.

When we issued the interim direction, my first reaction was that we shouldn't have to tell people that they need to be regulated. I think Ontarians and Canadians would say that if you're going into business and you are providing needed medications for patients, part of the responsibility is that you're meeting the appropriate safety and quality standards. I think the confusion or the difficulty in this situation is that based on those details, and based on how you structure yourself, you could fall under one or the other. We knew about that and that's why, when we're moving forward with guidance documents or anything that's available for industry or we're giving advice to industry, we're trying to lead them through that process. But it still really is on a case-by-case basis.

When we were going forward, I think it got to the point where we were saying, "We've clarified, we've re-clarified, we've reissued, we're doing it again. It seems like there still is this category that doesn't naturally fit into one or the other, so let's create a special category for it and we'll regulate it to that point." I think that's the tipping point that we're at at this point in time.

Mrs. Jane McKenna: I guess anybody here can speak for this as well, because we've had so many people in here, but Ms. Zaffiro, when she came, said that she called numerous times because she was totally new to this process, she had never done this before. She phoned over to the federal, phoned over to the province numerous times to say, "How do I get regulated? I am now in this process." She was totally in the dark of trying to get someone to call her back, someone to get answers from, and couldn't get any answers from it at all. So that to me is a red flag, red bells: that this woman is now trying to get answers from the federal, trying to get answers from the province on how she can become regulated, and she couldn't get any response back from that. To me, if I'm at the other end of that call and I've got someone who clearly is in a grey area and doesn't know what to do, but she's out trying to figure out that information and still can't get an answer from either of you—how do you fix that, then? That person actually was trying to get things in motion and couldn't, so how do you fix that?

Dr. Supriya Sharma: When I heard that testimony, I had the same reaction as you did—absolutely. I looked through it, and then I went through our records. I don't have all of the emails, because I know you've got—

Mrs. Jane McKenna: There's lots of stuff.

Dr. Supriya Sharma: There's lots of paper, but maybe just to use one example: For example, we got a call—actually, it was a call from an administrative assistant—into Health Canada on January 10. Between January and February, there are about 12 or 13 back-and-forths in terms of emails that were not submitted to the committee. I'm happy to provide those to the committee, but they weren't discussed. So the question that came

into our group on the controlled substances side was—the email was asking, "We would like to have a dealer's licence for a controlled substance," because Health Canada also regulates on the narcotics side any risks in terms of diversion of the product. So on January 10, that comes in. The next day or the day after, a message went back to Marchese to say, "Absolutely. Here's a dealer's licence. Here's the package." Then a message comes in on January 16 from an email, saying, "Okay, we need a dealer's licence. Can we get more information on it?" We said, "Yes, absolutely. Here's the package. Here's your dealer's licence application"—January 18. And there was a call, and we went through those.

The first email that came in was, "We need a dealer's licence. We need it by February 1." To get a dealer's licence for controlled substances takes, on average, four to six months. If we have to do a criminal record check, that in and of itself takes 75 days. So you also have to sort of say, "If you don't know what you're getting into, you need to educate yourself." So all of that information was provided, and there wasn't an application that came in.

We can go through it again. It was back and forth. I think we sent the application on three separate occasions. There were at least 12 or 13 times where we confirmed that we need the dealer's licence, and we didn't see that. We didn't see that coming in.

So I totally respect that somebody wants to be regulated, but it's not good enough to want to be regulated; you have to be regulated. I have to say that at no point in time did the Ontario College of Pharmacists nor Health Canada ever decline to regulate. What we didn't do a good job of—and I have to fully admit this—is that we didn't do a good job in saying exactly what framework the company would fall under.

But in the call—I think it was on February 7, 2012—when one of our GMP compliance specialists spoke to Ms. Savatteri, she said that for your admixtures, you would need DINs, which are drug identification numbers, and you would need an establishment licence. If you're going through that level of regulation, that process, from the time that you start to the time that you get your establishment licence and all your products through the process, can take 500 days. It's not reasonable to come to Health Canada in February with a business case and expect to be shipping product at the end of that month.

I think there are a lot of details in terms of how that communication took place that weren't completely reflected in the testimony that was given. But as I said, we are fully cognizant of the fact that we should have done a better job in terms of saying more directly that this is how you should be regulated.

Mrs. Jane McKenna: So I guess my thing is, just because I've sat through all of this whole process myself—the thing that I find extremely frustrating is, how is she supposed to know all that? You're clearly saying all of those things are exactly what's supposed to happen, but if I have an insurance fellow and he's telling me how to do my insurance, I don't know the questions to ask

him. That's this job, to be able to educate me on what I need to know and not know. So I just find it a bit patronizing when you say—because I'm not saying that it's not true. But to sit here and say, "Well, she should have known that you can't have it in 500 days" or whatever—the woman sat here, and there's absolutely no way she would have known that in the first place, because she was brand new to it. So if the fact is that she shouldn't have been able to get this in the first place, where was the ball dropped? I guess that's where I'm confused, because the ball has dropped somewhere. This woman has been given this contract. A broker has gone in and given it to her. There's clearly miscommunication, because Baxter was one on one with the hospital. There was no middleman. The contract was written totally differently than how Baxter understood it. But my point is, to me, the frustrating thing sitting in here—I won't speak for anybody else—is that everybody just keeps saying what everybody else should have assumed to know, but how in God's name is anybody supposed to know that when they've never been in this process before?

1500

We have all the information of everybody sitting in here. We've all sat through it. I know you watched it and listened to it, and you've definitely educated yourself on it. The ball was dropped, period. So who's owning the ball that was dropped? You can't expect somebody to know all of those things—and to say, "How would you expect to do that by February," when she had no knowledge of any of that herself?

So do we go back to the contract at the very beginning from Medbuy to her, that she shouldn't have been able to have that? I mean, I'm just curious.

Let me just quickly say this. When one of the recommendations from Thiessen, number 10—he was very specific when he said, "Health Canada shall license all enterprises that function beyond the product preparation permitted within a licensed pharmacy; that is, all product preparation enterprises not within a licensed pharmacy shall be licensed." So he was very clear that that needed to be done.

I don't know. I guess I'm just frustrated sitting in here, because we're not here to finger-point and to say whatever. I'm just saying, clearly, when you have a process that doesn't work—we have sat through people over and over again. When you say that you're having these committees and you're going to have the end result, we would really like to see that end result, because unless you're prepared to implement whatever you're doing, it's null and void for me. There's just no point to it, for myself.

Dr. Supriya Sharma: No, absolutely. So in terms of Dr. Thiessen's recommendation number 10—I think I have it committed to memory—we made the commitment to do that. When we're talking about the committees and all their work, they're really all directed in doing that: licensing the pharmacies that are not otherwise accredited. Then, we're working through the

logistics of all of those processes to put together a framework to be able to do that and are committed to implementation. So I can say that with 100% certainty.

My objective in illustrating, just on the controlled drugs and substances side, was not to sort of be defensive or not to say anything about what we couldn't do better—but in that case, exactly, you're not expected to know it before you ask the question. Once you've asked the question and you've got a direct response, then the responsibility does go back to the company to say, "Okay, I've been given this direction. If I want to be able to say that I want to be regulated, then I need to take the steps." When we did get to a place with Marchese where they do have a dealer's licence, we sent them the application again. We did teleconferences. We answered all the questions and helped them through the process of doing the inspection. But that is all premised on them actually giving us an application and taking that step forward as well.

Mrs. Jane McKenna: Could we ask to see all that, to get all that? Because we don't have that, do we?

M^{me} France Gélinas: We've got bits and pieces.

Mrs. Jane McKenna: We have bits and pieces. So I'd like to actually see exactly what physically those email back-and-forths were so that we can actually—not that it's hearsay, it's just that we don't have all that. We've got bits and pieces of that.

Dr. Supriya Sharma: Absolutely, and we would want you to have the complete records.

Mrs. Jane McKenna: The other thing is that while Dr. Thiessen was here, he said that over time—now, this is what I wrote in my scribble here—the responsibilities of the province and federals have eroded over time and it has become accepted that things have kind of just become convoluted, because there has been such grey area everywhere. Would you agree with that, with what he said there, that it has kind of eroded over time?

Dr. Supriya Sharma: I don't have the transcript in front of me, but I think he went on to kind of clarify a little bit about what he was talking about. But in terms of our relationship when we're talking about pharmaceuticals, we actually have a very good working relationship in terms of the federal, provincial and territorial levels because—I know this is going to sound like a bit of irony—the roles and responsibilities are quite clearly delineated. We don't have a lot of situations where there's confusion about who does what. We have areas where we definitely need to co-operate, because it is a continuum of health care. In terms of patients getting medications, there's a whole life cycle that's involved. We've had a really good working relationship. We do have discussions. We look at the risks and benefits of products. Obviously, the province has to look at cost-effectiveness; they have different issues that they deal with in terms of the delivery of health care. I think that that relationship has been very good, and we continue to work together with them.

Mrs. Jane McKenna: He can ask some questions next, but I'm just hoping, in the end of all of this, that it

becomes clear as ice, that everybody knows exactly what they're doing, because when you have companies that are out there and it's not written down that everybody understands the role of what to do, the people that are affected are the people that—obviously, the 1,000 chemotherapy people that are affected by this, right? If it was so clear, we sure as heck wouldn't be sitting here today or going through the process that we've gone through.

Anyway, I want to thank you very much from my side of it. Do you have any questions?

Mr. Rick Nicholls: I've got a couple.

Mrs. Jane McKenna: Okay. Go ahead.

Mr. Rick Nicholls: Thank you very much. Good afternoon, Doctor. Just a couple of things, as I'm relatively new to this particular committee. Not that we want to be pointing fingers, but again, I guess one of the questions that I would have to ask is: What's being done to those individuals or companies who erred in the mixing itself? I have a little saying that when you mess up, you fess up, but in this particular case, when we think about the patients who have been affected—what is being done in this particular case?

Dr. Supriya Sharma: Just to clarify, what has been done in terms of Marchese as a company or—

Mr. Rick Nicholls: Yes.

Dr. Supriya Sharma: Obviously, we found out on April 1 that this happened. We went in with the Ontario College of Pharmacists and talked to them on the 2nd, went in on the 3rd and got more information about the company. I think the immediate thing that happened was that the hospitals that were getting chemotherapy admixtures all took that activity and brought it in-house. I think that was the immediate concern: For the products that were affected, let's deal with things immediately. Then we went through the process with the Ministry of Health and the Ontario College of Pharmacists to get a sense of the company and how the company was structured.

I think a number of things have happened. I think the most significant part of it, though, is that when Ontario moved forward to put forward their recommendations and regulations on the drug preparation premises, it meant that Marchese as an institution has been inspected, so that there were standards that were put in place. They were inspected against those standards, and then they have since passed those standards. So they've been brought into a regulatory framework, and they are now, for all intents and purposes, regulated at the provincial level. As we move to our new framework, we'll have to see how that then plays out with respect to how they're conducting their activities in the future.

Mr. Rick Nicholls: Well, recognizing that the errors had been identified, I guess an obvious question I would have is, are there any repercussions because of it? I know that new standards have been put in place and you're following maybe some new processes and/or procedures, but something happened that caused all of this. Good is coming out of it, but again, when you look at the company that is doing the mixing and so on—I look at

the qualifications of those people, and obviously the ball was dropped somewhere along the line. I guess I'm concerned about repercussions—not so much standards that are being put in place so this wouldn't happen again, but the repercussions that would be put in place as a result of the error—human error, I suspect.

Dr. Supriya Sharma: I'm not sure in terms of what you were referring to when you were saying repercussions. Do you mean legal—

Mr. Rick Nicholls: Well, again, somebody is ultimately responsible—the overseer. Who would that overseer be at this particular place? Not that I need names; I don't need that. But my point being is that somebody—

The Chair (Mr. Ernie Hardeman): If I could just stop you there for a moment. I mean, you can ask any questions you like, but I think it's fair to assume that the presenter was thinking of questions that relate to her presentation. The overall picture of who's going to be liable or what went wrong—I think we leave that to the committee's discussion after the fact.

Mr. Rick Nicholls: Okay.

The Chair (Mr. Ernie Hardeman): So stay with the questions to the witness that would pertain to the witness's expertise.

Mr. Rick Nicholls: That's fair. Okay. Well, then, looking at the other questions that I have here, I have no further questions at this point in time.

The Chair (Mr. Ernie Hardeman): Well, thank you for giving me that opportunity to speak once.

Ms. Gélinas?

M^{me} France Gélinas: Just so that I use my time wisely, how much?

1510

The Chair (Mr. Ernie Hardeman): Four minutes.

M^{me} France Gélinas: I have four minutes? Okay. The first one will be very quick. It's a comment that you made to Helena when she was asking about how many different purchasing organizations exist out there. You talked about what happened in BC and what happened in Alberta and that the Ontario Hospital Association had done something that describes what happens in Ontario. Have you seen this document?

Dr. Supriya Sharma: Yes. I was referring to the Ontario Hospital Association survey. They actually surveyed all their hospitals to look at what products were being outsourced, what categories of products and the drivers for that outsourcing. My understanding was that was something that was tabled with the committee.

M^{me} France Gélinas: Okay. Somehow this does not ring a bell with me that we have seen this. Clerk, if you could make sure that we have a copy of this because it does not ring a bell with me, but I would sure like to have a look at it.

Dr. Supriya Sharma: It's publicly available, so I can resend the link as well.

M^{me} France Gélinas: Okay. Thank you. That was one thing.

Then my question has to do with how Marchese had just been awarded a multi-million dollar contract from

Medbuy. They reached out to you and—well, first, they reached out to the College of Pharmacists and realized they could not be licensed there, so they reached out to you and told you that they have a deadline that is completely unattainable. You have now been made aware that there is a company that is not licensed under the College of Pharmacists, because they've told you this, and that asked to be licensed on a deadline that is not feasible. Nobody looks beyond that as to making sure they don't go on and do something they're not licensed for?

Dr. Supriya Sharma: That's a really good question. When Marchese first came to Health Canada, their first documentation was saying—basically they came as Marchese Health Care and they said, "We are an accredited pharmacy and we are thinking about going into business, providing this type"—well, it was a type of service. They didn't talk about the type of service, but they had a series of questions that they wanted answered. They've subsequently come back to us and have said, "We are not going to be an accredited pharmacy," and then a third occasion they came back and said, "We would like to be a hybrid facility, a combination between an accredited pharmacy and having a good manufacturing practice and manufacturing facility."

So during the course of the discussions, it was shifting a bit in terms of their business model. Our understanding was that they were still exploring options, and as late as February 2012, that was the first time we actually saw on paper what a business plan might look like. Again, it was sort of just in general terms. Again, all of that was in the future tense. We weren't aware—and I think in retrospect, we should have been aware—that they were already shipping product out the door. We weren't aware, when they came to us in November 2011, that they were bidding on a request for proposal. If we have to go back and look at things, it's that communication that was missing, and I think we can do a better job of that.

I have to say that's all in the context of the fact that we're not used to companies going into business and supplying medications, especially something like chemotherapy to adults and children, without being regulated. Even on the controlled drugs and substance side, when we were looking at the dealer's licence part of it, when we were talking to them, they were putting together approaches and they said, "Well, we can either take this approach or we can take that approach." So the question was, "Well, what would you normally do in a situation where you have a company that's providing necessary medications and they don't have a dealer's licence and you have to do something about it?" They said, "We've never had that situation before. If we've had to do compliance and enforcement, it's always been in a company that has been regulated, then there's been an issue and then we've had to step in."

It was a very unusual circumstance. Should we have known about it? Yes, but the way that the system is working, you have companies that seek to be regulated. There are processes by which they submit applications to

be regulated. We didn't ever get those applications. We have correspondence from the company that says they were seeking to be regulated by the Ontario College of Pharmacists. When we spoke to the Ontario College of Pharmacists, they were hearing that they were seeking to be regulated by Health Canada. I think that's where we've needed to be able to make sure that we have those communications, and we do now.

Marshall Moleschi, who has testified in front of committee—I think he and I have each other on speed-dial. As we moved forward on the Marchese file, there were a number of situations where companies were coming to us and saying something, and then when we talked to the Ontario College of Pharmacists there was a slightly different representation of facts. It served us really well to work together and to decide how we were going to approach it together. Then when we sent letters to companies, we sent them either under a joint signature or we sent them with the other organization c.c.'d, so that companies knew that we were talking to each other. In terms of moving forward, that's a really good model of how to address it, to make sure we're aware of what's out there.

As I mentioned, we have companies that come and seek advice on business proposals, and they may go into business a year from now, five years from now, 10 years from now, or they may not go into business at all. I think we have to think about how we follow up with those companies as well.

M^{me} France Gélinas: You mentioned that you are presently creating a new category—

The Chair (Mr. Ernie Hardeman): Thank you. You can finish that one question and then that's it.

M^{me} France Gélinas: You are presently working on this new category for what you call commercial compounding etc. How many businesses do you figure would fall under this new category that you're working on?

Dr. Supriya Sharma: We can look at estimates. I think it's really difficult to know that. When we were talking with the Ontario college around their drug preparation premises, they were saying that they expected five or six companies to come in under that category; there have only been two. I think what will happen is that we need to put the proposal out. We need to do consultations on what it would look like, and then when we move forward to finalizing that and implementing that—the industry landscape shifts, and we've seen that. When you put regulations forward, it shifts. So companies will decide that they would like to be in that category and may structure their business to be in that category. Other companies may decide that they don't, and they want to go another route. So I think it's really difficult to predict.

When we did our survey and our outreach to companies, we had 14 of them that came forward and said, "We are conducting these types of activities." We expect there would be at least a subsection of those that would come forward in this new category, but I think in terms of the future, we'd have to see where the industry goes, and that really depends on the drivers within the health

care system, what kind of services are being provided and where the health system feels there is a need for those services.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair. I think the Ontario Hospital Association survey is something that was referenced in Elaine Campbell's memo of October 9. So I'm sure we're going to be able to get hold of that.

The fundamental problem in this whole tragedy was that Marchese Hospital Solutions assumed that the cytotoxic agent was going to be delivered to one patient. The entire bag was going to be delivered to one patient, and they did, as we know, try and reach out to Medbuy to clarify in some fashion, and they never got a clarification. They in fact were told that there didn't seem to be "any clinical impact from changing the volume." I'm quoting now from an email from Ron Swartz that we have on our desks today.

Anyway, that fundamental error of not understanding how the product was to be used at the end of the day was what caused all of this. Are you confident that the type of oversight by Health Canada, the work that you're doing with the provinces, the work that the College of Pharmacists is going to be doing here in Ontario, could or will prevent this kind of miscommunication?

Dr. Supriya Sharma: The hope and the intent is that when we're putting together the framework, part of that framework will concern itself with labelling. We're in the process of taking a look at what requirements are already there for labelling. So whether it's the USP labelling, whether it's what provinces are using, whether it's British Columbia or Quebec, we're working internationally with our counterparts to see if they have systems or ideas for us that we can incorporate into our thinking. So what we'll be doing on the labelling is putting together our best representation of what a label should look like, and the hope is that standardizing that labelling will go a long way in terms of making sure that it's an accurate representation of what that product is. It'll give people guidance on how it's supposed to be used.

Having said that, it can't replace that point-of-care assessment of what the product is, what the dose is and how that should be delivered to the patient. When we're looking at these products that are prepared in a facility, if they're being used as more bulk preparations or stock preparations, the product that actually reaches the patient won't have the label that we're working on; it won't have the drug information number that we've authorized as Health Canada, because it has now been subject to

another process and that has a label. But then, within the hospital system, once that bulk product is used for an individual patient, there's an individual patient label that's put on it as well. So I think what is really the lesson learned through all of this—and again, it's not specific to Health Canada—is to make sure that everyone along the way has a really good understanding of what the product is and how it's supposed to be used.

In summary, I think the Health Canada requirements that we're putting in will go a certain way, and then we still have to have respect in terms of the practice of pharmacy and the practice of medicine in that they will look after the part where it actually talks about the dispensing and the prescribing and the medications actually reaching the patient.

Ms. Helena Jaczek: Wouldn't it be fairly easy to just have on the label, "For multiple patient use"?

Dr. Supriya Sharma: That's actually one of the things that we're looking at: How do you express that? One of the things we're looking at is, we would either say, "For multiple patient use," or put it in the negative. So for the ones that are designed for single use, we would put, "For single use only"—something like that. But certainly those are things that we're exploring, as to how to best do that, and we have to do it for products across the spectrum. We're talking about this as one category, but we're looking at sterile preparations, and within sterile preparations there's going to be risk stratification and non-sterile preparations, and they have different risks associated with them. So we want to make sure that we have requirements that are fit for the purpose for the different levels of risk.

Ms. Helena Jaczek: As you've said, you, as Health Canada, accept Dr. Jake Thiessen's recommendations—as do we, of course—and you are drilling down even further, as you've described, with this national strategy and various subgroups looking at these particular areas, such as labelling and so on. I find that very reassuring. Thank you, Mr. Chair.

The Chair (Mr. Ernie Hardeman): Any further questions from the official opposition? That concludes the questions, then. We thank you very much for coming in and making a presentation and for making yourself available to the committee for that information.

That concludes the presentation part of the meeting today. We will go in camera to discuss the writing of the report. We'll just take a couple of minutes to, as they say, clear the galleries.

The committee continued in closed session at 1523.

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Official Report of Debates (Hansard)

Tuesday 22 October 2013

Journal des débats (Hansard)

Mardi 22 octobre 2013

Standing Committee on Social Policy

Local Food Act, 2013

Comité permanent de la politique sociale

Loi de 2013 sur
les aliments locaux



Chair: Ernie Hardeman
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 22 October 2013

Mardi 22 octobre 2013

*The committee met at 1601 in committee room 1.*LOCAL FOOD ACT, 2013
LOI DE 2013 SUR
LES ALIMENTS LOCAUX

Consideration of the following bill:

Bill 36, An Act to enact the Local Food Act, 2013 /
Projet de loi 36, Loi édictant la Loi de 2013 sur les
aliments locaux.

The Vice-Chair (Mr. Ted Chudleigh): We'll call the meeting to order. Thank you very much for attending.

A matter of business: The deadline for filing amendments to the bill with the Clerk of the Committee shall be 12 noon on the sessional day before clause-by-clause consideration of the bill, which is Monday, October 28, 2013. A hard copy and an electronic copy have to be filed with the office of the Clerk, Mr. William Short. Please note.

SUSTAIN ONTARIO

The Vice-Chair (Mr. Ted Chudleigh): We now have Sustain Ontario as our first deputation, if you would come to the table. You will have a five-minute presentation, followed by three minutes of questions from each party. When you have a minute left in your five-minute presentation, I will give you a little signal. You can continue right on; you don't have to acknowledge it. I'll politely cut you off at five minutes.

Thank you very much. If you would state your name for the purposes of Hansard.

Ms. Carolyn Young: My name is Carolyn Young. I'm the program manager at Sustain Ontario, the alliance for healthy food and farming.

Thank you to everyone for having us here today. We really appreciate the opportunity to have a chance to speak on this very important bill. We understand that the legislative committee on social policy is reviewing Bill 36, the Local Food Act, and has asked for submissions with regard to the bill.

Sustain Ontario is an alliance for healthy food and farming and was established in 2009 to be the provincial voice for organizations looking to improve our food system into one that is healthy, equitable, ecological and financially viable. Currently, the alliance has over 420 organizational members from across the province,

including the private, public and not-for-profit sectors. I think a lot of them are actually presenting to you, which is a really great sign that we are making an impact here.

Just to give you an example of some of our members, we have both the Holland Marsh Growers' Association and FoodShare on our advisory council. We have Ontario Nature and we have The Stop. We have a really cross-sectoral partnership with all of these organizations and alliances, and we search for cross-sectoral solutions to issues around food. That's a little bit about us.

First off, I want to say thank you so much, and I want to applaud the government in introducing Bill 36, An Act to enact the Local Food Act, 2013. Also, to those of you who have helped to move it along, we're really excited for it to get passed in the third reading.

Such legislation serves to highlight to the public the importance of local food and farming systems across Ontario, and when I use the words "food and farming systems," I am referring to everything from seed and inputs to eaters and to waste. We try and look at things from across the system, from retailers, distributors, growers, processors, eaters, etc.

Considerable work has been done already on developing local food systems, but much more needs to be accomplished across the province to ensure that Ontario's food system is healthy, equitable, ecological and financially viable.

We hope that the goals and targets spoken of in the Local Food Act will measure not just overall economic growth, but will also consider the measurement of local community resilience, for example, and economic development, but also the environmental impact of local food systems and, with the high standards that we have in Ontario, how we're comparing to other places, I think, and, the health outcomes that are related to local food for Ontarians and in improving our local food systems.

We appreciate that these goals will be published and the government will follow up with a report on the degree to which they have been achieved. We like a transparent approach, and we feel that this has been achieved to some degree with these consultations and how much people have been involved in this.

I also want to say that the inclusion of public metrics helps ensure action and achievement. We also hope that the government considers establishing an inter-ministry mechanism to ensure public policy and programming on food and farming come from various government departments and agencies and are better integrated and consider

input from engaging a wide spectrum of stakeholders, from farmers to consumers.

I think there have been some great opportunities in the last year to showcase this. For example, the Healthy Kids Strategy that's taking place right now and the Ontario Poverty Reduction Strategy are areas where food is a central piece. There's really a great opportunity here to leverage both the Local Food Act and some of this other legislation and programs that are being put in place across ministries.

While Sustain Ontario looks for the timely passage of the proposed Local Food Act, we feel the Local Food Act should do more than promote awareness and strive to improve procurement. We believe the key to really accomplishing the goals of stronger food systems in Ontario lies in improving the food literacy of all Ontarians.

In the short term, this means food awareness programs, including nutrition and food preparation programming. Longer-term investment includes a strong food literacy component in our school curriculum and hands-on food skills training in our school system. Food literacy programming strengthens our local food system, but it will surely translate to a healthier population as well. We've attached a backgrounder on that as well.

We also believe that it's important to emphasize food access to culturally acceptable foods and nutritious foods, to all people at all times. This is an important issue and should be included in the Local Food Act as well.

Another piece is around our belief that "local" should not only be about Ontario food but also about strengthening our regional economies.

Finally, we strive to complete environmental goals. We hope that you will consider those with this Local Food Act as well.

Thank you very much.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll start with three minutes of questioning with the official opposition: Mr. Hardeman.

Mr. Ernie Hardeman: Thank you very much for your presentation. I think it pretty much covers off the gamut of what's in the bill.

I think there are two issues. One is the issue of education and how one would go about putting doing better education for our young people in the bill. The other one is the definition of "local," and you mentioned that near the end of your presentation. Of course, in the bill, "local" is defined as "Ontario." There was some discussion about the problem if you change that. How do you then define "local"? Is it so many kilometres? What if it's one kilometre further and you can't buy that? It runs into a bit of a problem. So if you could just give me a quick overview of your answer to those two.

Ms. Carolyn Young: Sure. On the subject of food literacy, I think that there's enormous potential within this. Obviously, we've gotten rid of our home ec curriculum in the past, and unfortunately, that has happened. I think teachers are a little bit fatigued with curriculum changes all the time.

But there's an enormous amount of energy and assets in this province of people who are working with schools to bring local foods into schools through student nutrition programs, but also through teaching kids how to grow and cook again from scratch, and understanding their food and agricultural systems.

I think that there's a real need to look long-term in trying to bring back those things into our school curriculum and educating teachers on how to do that kind of work. But in the short term, there's lots of support that can be put towards some of these groups, such as Food-Share, The Stop and some of the more regional student nutrition programs that are doing this kind of work in schools. They're working with teachers to bring in gardening programming and hands-on food skills into both after-school programs and into the classroom.

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As for the local food piece, we've just conducted a survey of over 280 people, most of them members of Sustain Ontario, who are really interested in local food. What they said, the general gist from that survey, was that they felt that there needed to be not only—I think the emphasis on the definition of "local" isn't necessarily the key thing. People want to know where their food comes from. It's about provenance, so when we're thinking about local food and supporting local food in some way, that there be a tiered approach, not only recognizing Ontario as local but recognizing, say, Ottawa as local, and looking to appropriate infrastructure and distribution for that.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll move to the third party.

Mr. Jonah Schein: Thanks for coming and for all the good work that you're doing across Ontario. There's some stuff that you didn't get a chance to talk about, and I'd like to ask you a little bit more about some of those things. You mentioned the Healthy Kids Strategy. There's a panel that was established. Ironically, it was called No Time to Wait, and we've been waiting for any kind of action for a year now. But some of these things that were put in there—there has been a bunch of food recommendations. The act itself that we have right now is enabling legislation. There's very little in it that actually will educate people in the province or actually move local food procurement.

Can you elaborate on some of these things that you have talked about here? You've talked about a school student nutrition program. How would that help to support local food?

Ms. Carolyn Young: I think leveraging some of this work that's been done to expand student nutrition programs—and my good colleague here, Alison from the Ontario Fruit and Vegetable Growers' Association, can talk to you a little bit more. But connecting farmer groups and farmers in Ontario to schools is a great cross-sectoral approach to both increase support to farmers in Ontario but also increase access in schools to healthy foods.

But in addition to that, what we're saying is that it's not about giving kids food; it's also about interacting

with that food. It's also about interacting with those farmers and ensuring that there is programing at schools that is working around that food so that kids understand where it's coming from and that they have a chance to cook it, yes.

Mr. Jonah Schein: And you talked a little bit about metrics. Would you advise us around settings some goals around how much nutritious, local food was in our schools and how much food education was in the schools? Does that make sense to you?

Ms. Carolyn Young: I certainly think that our alliance is interested in increasing local food over the next few years. I think we can look to some other provinces for how they've approached this. But I also think that improving our targets is the main goal. Whether we set them or not is up to you fine folks.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We can move to the government. Mr. Crack?

Mr. Grant Crack: Thank you very much, Mr. Chair. Bonjour Carolyn, ça va bien? How are you?

Ms. Carolyn Young: Good, thank you.

Mr. Grant Crack: Good. Okay, so you had talked and just briefly mentioned targets in the legislation. Maybe if we have enough time, too, I'll just talk more about food literacy. But with regards to the targets, how do you see us moving forward with targets and being able to implement and hit those targets? And, maybe, what type of impact would that have on trade regulations or agreements as well?

Ms. Carolyn Young: Right. I think we definitely need to be careful as CETA and Canada are starting to look towards trade agreements—the Canadian-European trade agreement. But I also think that there's a need to work with public institutions to figure out targets. We have to set a benchmark for our targets to reach. So we have to know how much impact we're having on the local food system in terms of purchases now in order to actually impact on targets in the future. I think it's important to work with institutions to establish those targets.

Also, again, I think that it's important for our regional partners, for example, those in the north and those in the east, that we're not just talking about Ontario food alone, but we're giving some incentive to improve on our regional economic development. One thing I want to mention about that is that we include forest and fresh water foods in our definition of local food. In the Ontario north, those are the foods that are making an impact in terms of economic development and have an impact on some of our most vulnerable communities, such as First Nations.

Mr. Grant Crack: So, in your opinion, do you feel that these targets would be legislated or perhaps aspirational, that we could work towards them? What is the position?

Ms. Carolyn Young: It depends on who you talk to in our membership as to what their considerations would be. I think it's important to have targets and to monitor what we're doing. At the same time, I would say that if there's

a way to constantly improve that, then that is the best solution.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Ms. Young. Thank you for coming to the committee. We appreciate your input.

Ms. Carolyn Young: Thank you for having me.

ONTARIO FRUIT AND VEGETABLE GROWERS' ASSOCIATION

The Vice-Chair (Mr. Ted Chudleigh): We next call the Ontario Fruit and Vegetable Growers' Association, a fine old organization of 135 years or so.

Ms. Alison Robertson: Oh, 150-plus.

The Vice-Chair (Mr. Ted Chudleigh): Oh, 150?

Ms. Alison Robertson: I haven't been there since the beginning.

The Vice-Chair (Mr. Ted Chudleigh): You have five minutes for a presentation, followed by three minutes each from the committee. I'll warn you when you get to a minute left in your presentation.

Ms. Alison Robertson: Thank you. My name is Alison Robertson, and I am the program manager at the Ontario Fruit and Vegetable Growers' Association. I work primarily with food access and student nutrition initiatives, specializing in procurement and distribution. Most of my work is with OMAF, the Ministry of Health and Long-Term Care, the Ministry of Education and the Ministry of Children and Youth Services, as well as related industry organizations.

As an organization, OFVGA is very supportive of measures and initiatives that increase awareness and consumption of Ontario fruits and vegetables. We believe that one of the keys to building a stronger local food system in our province is improving the basic food literacy of Ontarians. People will not buy our products if they don't know what to do with them.

I'll give you a little quick story. I volunteer at the Royal Winter Fair. Last year, we had a loop going of horticultural planting and harvesting. A lady was standing watching. She was middle-aged and a very average, normal-looking person. I could tell she was going to ask me something. She turned at the end and said, "Carrots, they grow in the ground." I thought of a lot of smart things to say, but I said, "Yes, and so do potatoes and beets." How do you tell somebody like that to eat local or buy in season when they don't even know that carrots grow in the ground?

We really think the key is, like Carolyn said, home ec, education. These kids are our future consumers. They are our future voters. They will be involved in procurement when they're older, and they'll be using our health care system. So we have got to educate these kids about home ec, and I'm not talking about learning how to make Baked Alaska. I'm talking about mandatory—boys and girls, school gardens, understanding agriculture, basic food skills and learning what is local and why it's important to our economy. It's going to give them better

food choices, not just for themselves but for their families.

There are a lot of school-based initiatives that are going on. OFVGA has been involved for seven years with the Northern Fruit and Vegetable Program. Every week, there are 36,000 servings of fruit and vegetables going up north, and a large percentage is Ontario product.

When we started this, a lot of parents said to us, "Oh, good luck. My kids don't eat fruits and vegetables." We found from the food handlers that at the beginning there was some waste. These kids had never had broccoli, cauliflower—and we're not talking way up north, we're talking Sudbury. The food handlers said that within a month the waste wasn't there. The kids were eating it. The teachers said that within a few months fruits and vegetables were coming in their lunch boxes and then the parents started calling the school saying, "Where do I get mini cucumbers? Where do I get cherry tomatoes?" We created a market. Those were our little consumers. It was so easy. We were told by the teachers that kids were behaving better. Bullying was down. It was just win-win-win all the way along. This is a great opportunity with this food act to get kids more involved and get fruit and vegetables programs right across the province.

The Local Food Act is also an opportunity to expand local food in our broader public sector institutions—schools, universities, hospitals—and I think it's got to be more than aspirational. I think we have to set goals. When I attend fruit and vegetable and farm-to-school conferences in the States, they don't worry about free trade. They just say, "You're going to buy local. You're going to buy state. You're going to buy country." There are points systems for local product. It's a delicate dance, but I think we've got to really push for this.

In order for the Local Food Act to be successful in supporting farmers, I think we have to reduce the regulatory burdens on farmers. I think that there are real issues, both horizontally and vertically, between ministries and between municipalities that can create some barriers for food production.

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Interjection.

Ms. Alison Robertson: Since I got the final tap there, I'm going to leave you with three things. I think that for the now, we have to set a procurement policy and go beyond aspirational. I think that for the future, we have to look at home ec; these kids are our future consumers, business people and policy-makers. And I think we constantly have to look at reducing these barriers to local food production and consumption. Thank you very much.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll start with the NDP.

Mr. John Vanthof: Thank you very much for coming.

Ms. Alison Robertson: You're welcome.

Mr. John Vanthof: I'd like to just pick up a couple of points that you brought up, mainly about beyond aspirational. I think we would agree that this bill is completely aspirational, and I think there's a difference

between setting out "thou shalt do this and this and this" and "thou may do something far off in the future." Could you expand on what you think would be something that would be more—

Ms. Alison Robertson: More teeth?

Mr. John Vanthof: More teeth than this.

Ms. Alison Robertson: I think that if we make it easier for people—I think that for school programs under Children and Youth Services, it's daunting for some of these people that are getting the product. If they can work with grower groups, if we can develop a better infrastructure and make it easier for Ontario products to get to these institutions, whether it's food hubs or whether it's central procurement, I think it will happen naturally. I really do. We just have to make it easier for people. Most people, I think, want to do the right thing. It's just that, a lot of the time, they just have to do what's easiest, so we have to make it easier as an industry.

Mr. John Vanthof: Okay. And could you expand a bit on a very interesting project in northern—

Ms. Alison Robertson: Fruit and vegetable growers.

Mr. John Vanthof: Yes. Would that work province-wide? Because you mentioned Sudbury, and—

Ms. Alison Robertson: You bet it could work province-wide.

Mr. John Vanthof: —I don't think Sudbury is much different than most of southern Ontario as far as buying product.

Ms. Alison Robertson: We chose one of the most difficult regions. In the winter, it's not easy getting fresh product that isn't frozen to Wawa, but we've done it.

Mr. John Vanthof: Wawa's different than Sudbury.

Ms. Alison Robertson: Yes, and we go all the way up to Wawa. They had snow in Hornepayne this week, and we get product there, so we figured that if we can do it there, we can do it anywhere in this province. It would be a pleasure to work on that.

The Vice-Chair (Mr. Ted Chudleigh): Good. Thank you very much. To the government: Mr. Crack.

Mr. Grant Crack: Thank you very much. I think we all really enjoyed hearing from your example about creating the school gardens and talking about relationships between farmers and students. Could you just explain what you meant by reducing the regulatory burden for farmers, and how that would actually relate to increasing the consumption of local food?

Ms. Alison Robertson: I am probably not the best person from our industry to talk about that, but I hear awful stories. This isn't an awful story: The Premier wants our industry to increase sales, to increase investment, and yet I hear stories from our growers about the MOE classifying rainwater coming off their greenhouses as sewage. So, you're running one way, and then you get pulled back another way.

Municipalities, the taxation: when you start doing value-added: You have a large farm operation; they're going to do baking apple pies as well as picking at the orchard, and then you get sidetracked with some of the municipal issues.

I think different ministries, both horizontally and vertically, have to understand how important agriculture is—the jobs it brings, the barriers we have—and work together to work through these so that agriculture can be successful and we're saving farming, not just farms.

Mr. Grant Crack: Okay, thank you. And you talked about goals and targets; my colleague from across the way had indicated set targets. From our perspective, we think that that's quite a difficult thing to legislate, and that's why this bill has been designed as such. I guess you could say it's aspirational, but it's also very encouraging, and we're hearing a lot of good feedback from stakeholders that we're on the right track.

Could you just confirm, one way or the other: Are you in favour of legislated targets? And if so, maybe you could provide some input on how we could actually work to set those targets.

The Vice-Chair (Mr. Ted Chudleigh): A brief answer would be appreciated.

Ms. Alison Robertson: Okay. Again, I guess I would go back to my answer there for the Northern Fruit and Vegetable Program, our first year. We run from January to the spring, right out of season for Ontario product, and we still manage 73% Ontario product. That was through working with grower groups. We didn't have the targets; we just wanted as much local product in there as we could, and by working with Ontario fruit and vegetable growers, that's what we were going to push. You work with the right stakeholders and you have realistic targets.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. You mentioned apple pie, so I gave you a little extra.

Ms. Alison Robertson: I knew who you were, so I thought I'd mention apple pies.

The Vice-Chair (Mr. Ted Chudleigh): We'll move to the opposition. Mr. Hardeman.

Mr. Ernie Hardeman: Thank you very much for your presentation. Since we're all talking about the three-pronged approach—the aspiration, the goals, and the targets and the hard caps or the hard targets—I think that's really where we somewhat have a difference of opinion. I don't believe you can have aspirations unless you have something to aspire to, and I don't believe that this bill does that. The question becomes whether we're aspiring to a target that we hope to achieve. If we achieve it easily, chances are, next year we should set it higher.

The other one—and I think that was mentioned by the parliamentary assistant—is that you put in, “We shall meet this goal every year, starting right now,” and mandate people that they have to meet that. Would you have any problem with setting the target as to, “That's what we want to aspire to,” and hopefully we hit it? Recognizing that the bill does include a section that says that every three years, the minister must do a report and post it on the website as to how we are doing in our aspirations, how do you define how we're doing if you haven't set any aspirations?

Ms. Alison Robertson: That's a tricky question. I think there has to be beyond vague aspirations. Maybe

we have to look at some of the other local food acts around this continent and see how they handled it, but I think you certainly need that goal; I do. I just don't know quite how you do it. But I think you need more than an aspiration; I think you do need some type of realistic, reasonable goal, and review it every few years and keep pushing the envelope.

Mr. Ernie Hardeman: But you don't see any need to have hard targets, to say, “Everybody must achieve this,” legislatively?

Ms. Alison Robertson: That may be hard to enforce.

Mr. Ernie Hardeman: Exactly. Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Thank you, Ms. Robertson. Thank you for attending.

Ms. Alison Robertson: Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Say hello to Art Smith for me.

ONTARIO APPLE GROWERS

The Vice-Chair (Mr. Ted Chudleigh): We'll now move to the Ontario Apple Growers. Mr. Gilroy, welcome to the committee. You have five minutes, followed by three minutes of questioning. When you have about a minute left, I'll give you the tap.

Mr. Brian Gilroy: Sounds good.

The Vice-Chair (Mr. Ted Chudleigh): As it's called now.

If you could identify yourself for the purposes of Hansard.

Mr. Brian Gilroy: My name is Brian Gilroy. I'm chair of the Ontario Apple Growers and a member of the Ontario Fruit and Vegetable Growers' board.

Good afternoon. I'm an apple grower from the Georgian Bay area. The Ontario Apple Growers is an organization of 215 commercial apple farmers. We produce about 42% of Canada's apples, with a farmgate value of somewhere in the neighbourhood of \$70 million. We grow a wide number of varieties of apples, but there are 17 major varieties sold through the retail chains.

An interesting note about apples is that we don't grow enough apples to meet the demand of any of the varieties that are sold at retail. So there's incredible opportunity for us to expand what we grow.

It's a fairly unique sector in the sense that almost all of the apple-growing area in the province is fairly close to a major body of water: Lake Ontario, Lake Erie, Lake Huron and Georgian Bay. The growth of a strong local food movement in recent years has been a significant positive for Ontario's apple farmers. We are fortunate to be able to benefit from the popular Foodland Ontario buy-local campaign, which is well recognized among consumers and is the envy of many jurisdictions. As well, retail stores are familiar with the program and allow point-of-sale materials to be placed next to in-store displays of Ontario-grown products. Despite this, we must still compete with international competitors on size, quality and, most significantly, price, to make it onto Ontario retail store shelves.

In normal years, Ontario apples are in the retail stores for 10 to 12 months. This is where a Local Food Act can help. As an organization, we support programming that will increase awareness and consumption of Ontario-grown fruits and vegetables and other farming commodities. A fundamental cornerstone of a strong local food system is the food literacy of consumers. You've heard a fair bit about that already, so I'm going to skip through the importance of home ec in the schools and hope that that will continue to be looked into.

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Health care is the gorilla on everybody's back these days, and the consumption of fruits and vegetables can only improve the health of Ontarians. With apples, it's kind of a symbol of health, so we strongly encourage everyone to make sure that they have their apple a day because it keeps the doctor away.

There are other school-based initiatives that Alison has just talked about, so I'm not going to go into that as well, but I'm a huge supporter of the fact that—in remote communities, type 2 diabetes rates are 100%. We can do something about that. Alison is a great coordinator and can get fresh fruits and vegetables to those locations cheaper than anyone else. I would strongly encourage that both those programs be expanded.

Some initiatives have already taken place to encourage the development of partnerships between farmers, food processors and institutions. In many cases, this not only supports local farmers and farm businesses and provides healthy meal choices, but buying local can also result in cost savings for the institutions.

We hear a lot about sustainable. I'm a big fan of sustainability, but farmers need some help in making some adjustments to some of the social programs that are being pushed. This cleaner water stuff—I'm a big supporter of it; everybody is. But the cost that's passed on to farmers has to be balanced somehow. You heard about rainwater falling off a greenhouse roof being called sewage. It doesn't make a lot of sense to me.

We support ongoing investments in this area, as well as environmental farm plans, which help the farmer be more environmentally responsible and upgrade areas. For me, one of the big things is keeping wildlife out of my orchard. Deer are a huge issue, and up until recently, we were getting some help with fencing to keep the deer out. We strongly encourage those types of things to continue.

Should a Local Food Act be legislated? Should there be hard and fast rules as to how much local needs to be in there? Well, the major retailers in this province sell most of the food. There are wholesalers, yes, and targets there are relatively attainable if you make it worth their while and if you help with the coordination—oh, did you knock?

The Vice-Chair (Mr. Ted Chudleigh): Yes, I did.

Mr. Brian Gilroy: I'm sorry.

The Vice-Chair (Mr. Ted Chudleigh): You've exceeded your time. Perhaps you can work in the rest of your comments during one of the questions, because the questions are usually very general.

Mr. Brian Gilroy: Absolutely. A fast five minutes.

The Vice-Chair (Mr. Ted Chudleigh): We'll move to the government. Mr. Crack.

Mr. Grant Crack: Thank you very much, Mr. Chair, and thank you, Mr. Gilroy. Maybe just to change a little bit here, you had a bumper crop this year, from what I understand, especially compared to last year.

Mr. Brian Gilroy: Some people, yes.

Mr. Grant Crack: Maybe you could just explain to us the type of work you do with Foodland Ontario and how you market some of these products, especially in the off-season, and how this act might help the apple growers.

Mr. Brian Gilroy: Sure. Apples have been a consistent client of Foodland Ontario, and we've actually received a bit extra this year to try and regain some of the lost shelf space. That is greatly appreciated. We're working hard with them. We're actually going to be doing some consumer sampling in February of next year. Movement is usually very strong in the fall months when apples are on everybody's mind, but later, after Christmas, it slows down a bit. So let's hope that this consumer sampling in a variety of stores in the GTA will improve consumption, and also point-of-sale materials, in-store competitions for displays and those types of things.

Mr. Grant Crack: Thank you. I think my colleague has a quick question.

Mr. John Fraser: Yes. I'd just like you to continue your train of thought when you were starting to talk about retailers there. I'm just interested in where you were going in terms of relationships with retailers, just when your time was intercepted.

Mr. Brian Gilroy: Retailers need to be a lot more supportive of local food, period.

Mr. John Fraser: Okay. Just in terms of what they need, because I know from your industry over the years, you've been improving quality, and because you have competition, mostly from south of the border—

Mr. Brian Gilroy: Yes.

Mr. John Fraser: So what have you done to increase that, and what more do you need from retailers? Is there stuff that they're asking you for that—

Mr. Brian Gilroy: Lower prices, lower prices, lower prices.

Mr. John Fraser: Lower prices. So that's what it is.

Mr. Brian Gilroy: Yes. Last year, apples, even at retail, went up a bit, and those who had apples received a significant return for their apples. But with our costs constantly going up, we need more than what we were getting 20 and 30 years ago. Unfortunately, we're not getting a whole bunch more than what we were getting 20 and 30 years ago. You know what's happened with the minimum wage, the price of gas, electricity, all those things. If we want to continue being Canada's main apple-producing province, we're going to have to do some things to get more of that retail dollar back to the farmer.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much.

Mr. Brian Gilroy: You're very welcome.

The Vice-Chair (Mr. Ted Chudleigh): The official opposition. Mr. Hardeman.

Mr. Ernie Hardeman: Thank you, Brian, for your presentation. I just wanted to go back to the apple a day and the health issue with eating local food. I always thought that the apple was actually the bribe because it was always the bright, shiny apple they took to the teacher. Now I realize that that was part of the education about local food in our schools that doesn't seem to exist anymore. Maybe that's what we need to do, is get education back to where the students come in with an apple. It would help your sales, and it would also increase the consumption of good apples.

But I really wanted to talk a little bit about the marketing of apples. You mentioned in the start of your presentation, in fact, that we don't produce enough to fill the market. We have to import. A lot of times I've noticed that the imports are not necessarily selling for less money.

Mr. Brian Gilroy: No.

Mr. Ernie Hardeman: So it seems to me that we need to get something in place that actually deals with why they're buying imports at a higher price than they're willing to pay for Ontario apples. I wondered if you could tell me a little about that.

Mr. Brian Gilroy: Well, let's see. Variety is a big thing. The Honeycrisp apple has been a godsend for a number of apple farmers who had the vision to plant those. They actually return to the farmer almost three times as any other apple. They're extremely hard to grow. That's why that price differential has been maintained.

Quality is a big thing, but we can compare—the whole national apple scenario was benchmarked last year through the Apple Working Group of the Canadian Horticultural Council, and I'd be happy to share the executive summary with anybody who's wanting to learn a bit more about how we do compare.

I think one of the big things is that Washington state produces as many apples as the rest of North America put together, and they have some very impressive marketing schemes that return millions of dollars to corporate head office at retailers in the way of volume discounts, promotional activities and those types of things.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. If we could move to the third party.

Mr. Jonah Schein: Thanks for coming in and for your comments today. You brought up a few things that are important to me. You mentioned the idea of an apple a day keeping the doctor away. We could create a market for Ontario-grown apples through our school boards in Ontario.

In 2010, our leader, Andrea Horwath, brought up the idea of setting local procurement targets for public institutions. One of those could be a school board. We could get an apple a day to every kid in this province. That would support your growers and would reduce health costs, I think. How would this affect setting targets there rather than for retailers? Have you thought about that as an option?

Mr. Brian Gilroy: Sure. Almost every school board, every school, has a breakfast program. One of the problems is that the procurement system is helter-skelter. It's all over the map. If it was easy for people to access Ontario-grown for those programs, it would make a big difference to Ontario farmers, in my opinion.

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Mr. Jonah Schein: Do you think that's viable? Can we get an apple a day to every student in the province?

Mr. Brian Gilroy: Absolutely.

Mr. Jonah Schein: What do you think the trade-offs would be if we spent an upfront dollar on an apple or a penny on that apple—a pound for a penny.

Mr. Brian Gilroy: We need a few more pennies for that apple.

Mr. Jonah Schein: There's some sort of metaphor there—a pound of prevention—

Mr. Brian Gilroy: But somewhere in between we're about right.

Mr. Jonah Schein: A penny for a pound of prevention—something like that.

Mr. Brian Gilroy: Sure. I think that overall the cost would be less for everyone involved if we can integrate procurement and need and the supply. If it can be integrated, coordinated—which is what Alison is an expert at—it can happen.

Mr. Jonah Schein: Student nutrition programs, breakfast programs are only about 10% funded right now by any kind of public funding, so we could bring that up much higher.

Mr. Brian Gilroy: I volunteered myself in some programs, and they're outstanding. They're being funded maybe 10% provincially but overall they are being funded. We're big supporters of all of those programs using as much local as humanly possible.

The Vice-Chair (Mr. Ted Chudleigh): Good. Thank you very much, and thank you, Mr. Gilroy, for coming in. We appreciate your input.

Mr. Brian Gilroy: Thank you.

CHRISTIAN FARMERS FEDERATION OF ONTARIO

The Vice-Chair (Mr. Ted Chudleigh): We can move now to the Christian Farmers Federation of Ontario. Welcome, Lorne. You'll have a five-minute presentation, followed by three minutes each of questions. I'll tap when you've got a minute left. Would you identify yourself for Hansard, please.

Mr. Lorne Small: Lorne Small, president, Christian Farmers Federation of Ontario. I'm a farmer and what I produce is consumed locally, so I'm at that end of the spectrum.

The Christian Farmers Federation of Ontario thanks the committee for considering our comments relating to Bill 36, the Local Food Act. The organization represents many thousand farmers across Ontario. The CFFO supports the approach being fostered by the current draft that seeks to encourage education, awareness and promo-

tion of Ontario-grown food over the regulatory approach. We also see opportunity in the Local Food Act to do more to help create a sustainable local food system in the province.

We support the concept of soft targets. First, it avoids the pitfall of triggering trade disputes over legislated local content. Second, target-based requirements rather than hard regulations on local content allow for more flexibility across the public sector as public sector institutions have different budgetary constraints and a different clientele that they have to service. The CFFO believes that using discussion-based soft targets is the best method of decision to enter into play setting those targets. The discussion process needs to recognize the spending limitations of public institutions, grower costs and limitations within the local distribution system to arrive at actionable, realistic goals. Idealistic, blind targets serve no one well.

Education: The CFFO notes that the proposed act is a good starting place for improving knowledge and awareness around local food. The CFFO supports the concept of a local food week as an educational tool. However, having it overlap with agriculture awareness week is a double-edged sword. The danger is that the local food week will overshadow agriculture awareness week, reducing knowledge about primary production. However, should the proposed overlap proceed, primary agriculture must take it upon itself to leverage the focus on local food as an opportunity to let residents know where local food comes from.

Other areas of support: The CFFO supports the current definition of “local food” as being food produced or harvested in Ontario. A more narrow definition would trigger a negative regulatory burden for Ontario’s food production and processing systems.

Possibilities presented by the Local Food Act allow some opportunities for Ontario residents and farmers. The CFFO believes that the Local Food Act can serve as a mechanism to enhance other areas of need in Ontario that are related to food in the following ways:

First, the CFFO believes that providing tax credits to farmers and food processors for donations to the food bank will help facilitate stronger supply procurement for Ontario’s food banks. The CFFO believes that this will be a positive step in supporting low-income families in Ontario.

Secondly, the CFFO supports an enhancement of the Foodland Ontario marketing program that can be leveraged from the Local Food Act, including expanding its mandate to include the restaurant and food service sectors in Ontario.

Thirdly, the CFFO believes that the Local Food Act can be leveraged to create a market-development program similar to the discontinued Ontario Market Investment Fund. The fund can be used to launch a diverse range of initiatives within the Ontario marketplace that strengthen and grow support for local food by engaging food-producing and processing businesses as active partners in local food.

Finally, the CFFO believes that there is a critical condition that could be addressed by the Local Food Act: the lack of coordinated aggregation of fresh fruits and vegetables from family farms. The significant technical barriers to entry into the food supply chain prevent many family farm operations from supplying public institutions.

At the same time, the CFFO recognizes that public institutions do not have the resources to deal with a large number of farmers to source their local food supply, nor are there incentives to do so when successful food supply companies exist that can consistently deliver what is needed when it’s needed, heedless of the source of the food.

Therefore, the Local Food Act should include support for aggregators of local food supplies from family operations to bridge the gap between the need for market access by family farms and the need for consistent supply for public institutions.

Thank you for your time and consideration. I appreciate this opportunity to be here.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Mr. Small. I appreciate your comments. We’ll move now to the official opposition. Mr. Hardeman.

Mr. Ernie Hardeman: Thank you very much for the presentation, Lorne. We much appreciate it. I want to go just quickly to the soft targets that you mentioned. An earlier presenter talked about how we could set targets for wholesale, but you couldn’t do that for retail. I want to point out that at least my objective would never be to tell people what they can sell in their stores, but the biggest food purchaser in the province of Ontario is the government of Ontario when you look at all the places where they, either directly or indirectly, pay for the food. When you speak of soft targets, do you believe that putting targets in regulations to aspire to—would that be called a soft target, rather than saying you must have 20% or 5% or whatever of Ontario food?

Mr. Lorne Small: I have a personal dislike for regulations saying, “Thou must do this.” I’m much more willing to co-operate with you if you say, “If we agree, this is what we hope to achieve.”

Mr. Ernie Hardeman: But if you do it that way, Lorne, how do you know what it is that we want you to do, if there is nothing out there to say, “We would hope to get to 20% or 30% Ontario?”—

Mr. Lorne Small: I think what our membership is saying is, have us at the table to discuss what we ought to achieve. If you say we’re going to achieve a 50% increase and we buy into that, then we’ll work towards that end, rather than saying, “Thou must do 20%.” It’s a conciliatory or co-operative approach.

Mr. Ernie Hardeman: But you do believe that at some point you need some target that you’re going to work toward.

Mr. Lorne Small: Oh, yes.

Mr. Ernie Hardeman: I think that’s what we’re saying. That’s not presently in the regulation.

Mr. Lorne Small: And it needs to be measurable and achievable.

Mr. Ernie Hardeman: Yes, that's the word I was looking for: "measurable." I want to thank you for your comments about Local Food Week. I think we all agree that we need a local food week. We also agree that we need an agriculture week, and putting the two together will likely negate a lot of the benefits of both of them. So I think we do need to separate them and have them both.

Mr. Lorne Small: To me—

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll move to the third party. Mr. Vanthof.

Mr. John Vanthof: Thank you very much for coming. I'm also going to continue—as a farm organization, I take it you would spend quite a bit of time looking at the Local Food Act. In the act, as it stands, would you say that there are even soft targets in it?

Mr. Lorne Small: I don't really see a lot of soft targets in there, but it allows the opportunity to start the dialogue on a lot of these issues and engage a lot of different players in the discussion. I think our word is a good start.

Mr. John Vanthof: But since this is legislation, would you, as a farm organization—if it was on another topic like nutrient management or something, would you say that you would like to pass legislation that had not even a directional goal? Because in the Local Food Act, I don't even see who would be consulted. It is so broad that—

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Mr. Lorne Small: You're correct. There's not a lot of detail there. We're optimistic that when you get to writing regulations, that's where you get who you want to consult with, what targets, what you are going to measure and what you are going to report on. Our expectation is that that comes in the regulatory process. We're good-faith people.

Mr. John Vanthof: You are aware that once it gets into the regulatory process, the public consultation part is kind of gone?

One more small point—it's not a small point. We fully agree that Local Food Week and Agriculture Week should not be at the same time. But do you think that the Local Food Act goes far enough on education? We've heard "home ec" so many times. I'm not that old, and I can remember home ec. What happened?

Mr. Lorne Small: I know that when you put an issue into the curriculum in the schools, it works. My children—I have five kids in school. They come home with that sort of stuff, and it does affect what you put in the grocery cart, so it works.

I have a concern. I sat on a school board for a period of time, and I have a little concern with continuing to put more and more stuff on the curriculum and forget what schools are for.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll move to the government side. Mr. Crack?

Mr. Grant Crack: Thank you, Mr. Small, for coming before us. From my opinion, and I think on the part of the government—I really appreciated your comments with aspirational over a regulatory approach, soft targets as opposed to hard targets. Trade disputes was a concern to you, and the flexibility in the different aspects of the public sector regarding spending and the costs involved.

But you made a comment concerning tax credits for farmers when they make donations to food banks. That's a very positive initiative, but from my perspective and our perspective, perhaps—do you have any ideas on how we could implement that based on the difference between rural food banks, smaller urban food banks, quality of product, value of product and how perhaps food banks and the government would be able to work with the CRA to come up with a solution to this potential initiative?

Mr. Lorne Small: Ideally, our organization would prefer that there was no such thing as food banks, that in fact they were not needed in a society, but they are. They're an institution. They're there.

I'm not a tax professional. I just think that many of our farm families would gladly donate produce to the local food banks. If there's a tax credit, they would welcome that. If there's not a tax credit, they'll still donate. I think it's one of those incentives to—every year, when you're filling out your return, it's a reminder that here's an opportunity that you could contribute to. So that's sort of our thinking: to donate to and help your fellow citizens from time to time. That's where our interest is in. The technicalities of it—I farm for a living; I can't be of much help there. Sorry.

Mr. Grant Crack: No, and that's perfectly fine. It's just that we find it a complicated issue to try to implement as well. I know that farmers do make substantial donations to food banks across the province, and we appreciate that and recognize that, so thank you very much.

The Vice-Chair (Mr. Ted Chudleigh): Good. Thank you, Mr. Small, for coming in. We appreciate your input.

Mr. Lorne Small: Thanks for having me.

GREATER TORONTO AREA AGRICULTURAL ACTION COMMITTEE

The Vice-Chair (Mr. Ted Chudleigh): If we could move now to the Greater Toronto Area Agricultural Action Committee. Welcome to the committee. You'll make a five-minute presentation, followed by three minutes each from each of the parties for questions. With a minute left, I'll give you a little tap as to "Your time has got one minute left." Would you please identify yourself for the purposes of Hansard?

Ms. Janet Horner: My name is Janet Horner. I'm the executive director of the Greater Toronto Area Agricultural Action Committee and the Golden Horseshoe Food and Farming Alliance.

Mr. Allan Thompson: Allan Thompson. I'm a regional councillor from the region of Peel, but I am vice-chair of the Greater Toronto Area Agricultural

Action Committee and also sit on the Golden Horseshoe action committee.

Ms. Janet Horner: And we're both farmers.

Mr. Allan Thompson: Yes.

The Vice-Chair (Mr. Ted Chudleigh): Thank you. Welcome.

Ms. Janet Horner: Thank you for the opportunity today to give you our ideas about what the Local Food Act should be and say to Ontario, both rural and urban. Our committee 18 months ago released something called the Golden Horseshoe Food and Farming Action Plan. It was a plan that, for the next 10 years, would help this food and farming cluster in the Golden Horseshoe attain some growth, and a lot of what's in the Local Food Act actually aligns with our action plan. So we think you're pretty smart people.

The first thing that we think needs to be in the Local Food Act would be a clarity of definition. We all know the morass we've walked into here with definitions all over the place. We feel that any definition should encompass food grown, produced, harvested, raised and processed in Ontario. I'm not sure how you'd wordsmith it, but we feel that the definition needs to incorporate all of those aspects, and we think that definition should be developed in tandem with CFIA and not out of step. That's our first point.

The second point talks about local food procurement. I've heard the questions you've had about this. We're not wanting a lot of civil servant jobs created to the enforcement of this thing. We do think there need to be targets, and we think that there could be a lot more time spent on helping the government of Ontario achieve those targets, but I cannot see a lot of time spent having to record every carrot that you buy, and so we've got to watch against that kind of saving nickels and spending dollars.

We encourage the province to adopt the system in provincial government ministries and helping and assisting municipalities, because not only will what you do affect your provincial ministries, but this will be a trickle-down effect to all of the municipalities across the province. They don't know how to do this, and I think we have an opportunity here to help them figure out how to do local food procurement, because it's big job to take on.

The next point I want to make is that we do support the promotion of food literacy in youth. The thing is, this act is not going to necessarily make that happen. There's got to be a meeting of the minds between the Ministers of Health, Education and Agriculture for this ever to go anywhere, and paying lip service to it in this act is not going to get the job done, and we all believe that needs to happen.

The provision of the tax credit for farmers—we agree.

The creation of a local food week separate from Ontario Agriculture Week—we agree. We also feel that you need to mobilize your communities and make sure that if there are local funds available to local communities, they will do a good job of promoting local food and their economies on the local basis.

We think there should be a local food soup day in conjunction with Local Food Week. What better way to get that word right out across the province and be a winner?

That's it, Mr. Chair. Allan is going to help me answer any questions.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll move to the NDP.

Mr. Jonah Schein: Thanks for coming in. You're raising concerns about the counting in terms of targets, and I'm curious if you've thought about what kind of targets would be helpful that would support local food in Ontario.

Mr. Allan Thompson: Well, I'm going to go off track because I think you've heard it from everybody.

Under a lot of municipalities now, we have procurement programs that you have to buy whatever. So a lot of people are hooked up with Sysco or Gordon Food Service. Gordon Food Service is growing from, what, 18% to almost 25% of local food. They'll fill the demand if the ask is there. Sysco is doing the same.

The big thing is, there are a lot of avenues that we can work through to get there. I think it's education and awareness and your responsibility.

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Food security—I know it's misinterpreted as a lot of things. To me, I think food security is making sure that we're eating what we're consuming. From all the groups here, I think that message is pretty much loud and clear, and that's the area.

I think we all need to set targets. To me, legislated, real quick—we said no, and to me, it's a lazy way of incorporating something. Then it's done and you walk away and nothing gets done. I think as long as there are targets, everybody who has skin in the game has to deliver. I think you have to set a target low and build on that. There are a lot of small municipalities. I also sit on the Rural Ontario Municipal Association, and the big challenge is that a lot of municipalities do not even have the ability to incorporate that in their own procurements, and it's a challenge. I think we have to engage in different ways.

Mr. Jonah Schein: I think I'm not quite understanding. What kind of target would you support? No firm target? Would you recommend a target for a public institution or for a municipality?

Mr. Allan Thompson: Absolutely, and—

Ms. Janet Horner: Recommend.

Mr. Allan Thompson: Recommend—I would recommend that you start. The big thing is, some people say 10%, 25%, where you want to go. I think you have to do that to find your comfort zone, to know what you really have out there.

We've also done an asset mapping through the Golden Horseshoe. It's to bring all the groups—we've got processors, we've got everybody here, but the right hand doesn't know what the left hand is doing, and everybody's trying to protect their own little kingdoms. I think it's time we break down those silos and start sharing who is really out there.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We move to the government side: Mr. Crack.

Mr. Grant Crack: Thank you, Mr. Chair, and thank you both very much. There's a lot of positive that came out of your presentation. I really appreciated your comments about the regional aspect and the good work that's being done across the province on a regional basis. I want to talk about that, and I want to talk about other things.

You had mentioned, Allan—can I have your last name again, sir?

Mr. Allan Thompson: Thompson.

Mr. Grant Crack: Thank you, Mr. Thompson. You're on ROMA; is that correct?

Mr. Allan Thompson: Yes, I am.

Mr. Grant Crack: So you must be aware that AMO is not in favour of any legislated targets—

Mr. Allan Thompson: Yes.

Mr. Grant Crack:—when it comes to this particular piece of legislation, due to the cumbersome burden that it would place on municipalities, hospitals and other public sector—I don't know if you wanted to talk a little bit more about that. And then, if I have some more time, I want to talk about the food literacy component as well. Go ahead.

Mr. Allan Thompson: Sure, certainly. Real quick, what I'm going to say is that I do believe there need to be targets, but you know what? If you set it at 10%, then next year you've got to be better than that—you're going to be 10% better. I think we have to constantly keep building; if you're not, then you've got to answer why.

A big challenge is, leave that flexibility open. It's the same as an apple a day, but look what happened last year. Mother Nature showed that the apple industry wasn't going to happen in Ontario, and we all experienced that. I think that's the area that we have to do. I think we have to encourage everybody to do it, but say, "Look, this is what we're asking from you. We're not going to legislate it, but this is demanded of you."

Also, health is really caught onto this. I really think that if we incorporate everybody, especially with schools—we're trying to get breakfast in classrooms; that's a hard sell, but we're getting there.

I think there are a lot of avenues, and I think we have to be creative. That's why I'm saying if you legislate it, then you walk away and then nothing is done. This way, everybody's trying to achieve and learn from others on how we're doing it. Again, I think that's where the municipalities and AMO need to step up to the plate.

Mr. Grant Crack: Thank you. Do I have any time left, Mr. Chair?

The Vice-Chair (Mr. Ted Chudleigh): Thirty seconds; time for a short one.

Mr. Grant Crack: Oh, great. Food literacy: I think you respect the fact that in this particular bill there's no mandate from the ministry and from the Minister of Agriculture and Food to make curriculum changes, but that's something, perhaps, that we could look at. I think most of us are supportive of looking at trying to promote food literacy in our schools.

I don't know if you have one second or 10 seconds. You want to talk about that?

Ms. Janet Horner: I think there needs to be a meeting of three ministers first.

Mr. Grant Crack: Okay.

Ms. Janet Horner: I was in a meeting with Deb Matthews one day, and she said she'd be willing to convene that meeting. We haven't seen that happen yet. I think the ministers have to figure out how they're going to be involved in the Local Food Act and how they can do something about local food literacy, and I think it will be up to them.

Mr. Grant Crack: And the three ministers are?

Ms. Janet Horner: Well, the Premier, Liz Sandals and Deb Matthews, yes.

Mr. Grant Crack: Thank you. I just wanted that on the record.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Ms. Horner and Mr. Thompson. Thank you for coming in.

Interjection.

The Vice-Chair (Mr. Ted Chudleigh): Oh, I guess we're going to have a question or two from—what is it?—the Progressive Conservative Party.

Mr. Ernie Hardeman: Thank you very much for your presentation. I was listening to your presentation and particularly liked increasing the definition of just "Ontario" to actually describe what "Ontario" means. Whether it's grown in Ontario, whether it's processed in Ontario or whether we just delivered to Ontario yesterday, it's a product of Ontario—

Ms. Janet Horner: Or whether we create those jobs in Ontario by processing it.

Mr. Ernie Hardeman: So I think that's worth looking at as an amendment.

I'm more interested, though, in the targets. I know everybody is suggesting that that's going to be problematic because it's going to put too much pressure on the buyers and so forth.

I just want to relate this, because our former Speaker is sitting here, and he was the Speaker at the time when this happened. But I went into the lounge upstairs, and obviously this place is provided by one of the food suppliers here in this Legislature. We went into the lounge and there were apples, and the apples had a little sticker on them that said "Product of Washington." It wasn't Washington in Oxford county. We actually did contact the Speaker of the day and he checked into it. After that time, the same supplier never supplied us with Washington apples anymore, because we wanted Ontario. That's how simple it was to buy local. I just wondered if we couldn't all get our minds around how you do that in wholesale.

Ms. Janet Horner: And, you know, sometimes it's not rocket science.

Mr. Ernie Hardeman: Hear, hear.

Ms. Janet Horner: I was a caterer for 30 years in my other life, and when I said to my supplier, "Do not bring me lettuce from California when Ontario lettuce is

available,” he never would, or I would sent it back. So we’ve got to just take the practical approach here.

If we look, we can probably say, “Oh, yeah. Most institutions are probably, even with eggs and milk and their basics, running in around the 18% as local already.” So if we can build on that and build on those numbers and say, “Okay, how be we aspire to...,” this is where we want to be. Let’s see where the spirit of this thing can go without bringing down the heavy hammer of the law.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Now our time is up. I appreciate very much your coming in and sharing your views with us.

Ms. Janet Horner: Thank you.

ORGANIC COUNCIL OF ONTARIO

The Vice-Chair (Mr. Ted Chudleigh): If we could move now to the Organic Council of Ontario. Welcome to the committee. You have five minutes for presentation. With a minute to go, I’ll give you a little tap, followed by three minutes of questioning from each of the parties. Would you identify yourself for the purpose of Hansard, please.

Ms. Jodi Koberinski: My name is Jodi Koberinski. I’m with the Organic Council of Ontario, and I will forward my talk for you folks to see by email.

The Vice-Chair (Mr. Ted Chudleigh): Thank you.

Ms. Jodi Koberinski: The Local Food Act represents an enormous opportunity to shape the future of food for Ontarians. The Organic Council, on behalf of our members in the organic sector, wants to start with thanking the Wynne government and the preceding government for initiating this act and getting the ball rolling.

We want to state unequivocally that we wish to see this act passed. We are not willing to give up, in the pursuit of the perfect—to miss out on the good in the meantime. So even though we have a number of things that we’ll bring to your attention that we think are missing in the act, we really hope that this Legislature will pass the act and we can build from there.

It’s a very simple act. It has three points. The first one: “To foster successful and resilient local food economies and systems throughout Ontario.”

Then it goes into a great deal of detail on definitions, and we get a definition for a hospital, but we don’t get a definition of “successful” or “resilient.” We think this is a huge oversight. I know, from the work that we do with our colleagues across the scale of agriculture, from permaculture all the way through to the largest industrialists, they will all answer what “resilient” looks like differently and what “success” is differently. So if we don’t take this on, we’re in a real hard time here.

For example, is it successful if we have more yield per acre but less nutrition per acre? Is it success if we don’t have the water and seed resources in a decade to produce food because we gave it up for profit today? So we really need to look at what we mean by “success” and “resilience.” I’m hoping that when we—you know, at the very basic level, success for the farming community is profitability, not productivity. Success may look like less

food dollars 30 years down the road because we have a shorter value chain because people are eating more direct from the farm and they are not going through a grocery store, but they’re getting maybe 30% or 40% of their food direct from a farmers’ market or a CSA. So we have to really be clear what it is that we mean by “success”—pointing back to what Janet said, this idea of our three ministries, education, health and agriculture, getting together and needing to discuss what it is that a successful local food system looks like down the road.

Local food is about a desire to connect with people; it is not simply a postal code. So I’m hoping that this act is something that can become aspirational. We have very immediate short-term, real targets that we’ll have to address, but there’s some medium- and long-term shaping of the food system that we could do through this act. I’m encouraging you as politicians to keep your eye on the long haul. This act will be in place for a long time, and I hope that we don’t end up putting something in place that addresses the needs of the immediate from the production side and gives up what’s good for the province over the long haul.

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I’d also like to request that we add some language in the preamble that recognizes that “local” is proxy for a lot of other values. In 2010, some research was done at Vineland, looking at the branding for “local,” “organic,” and “natural.” Sixteen per cent of the respondents thought local food meant GMO-free. Clearly, there’s a lot of deep misconception about what local food is. I think if we don’t acknowledge in the act that “local” means a lot of different things to a lot of people, we hamstring ourselves to a postal code over the long haul or to greenwashing by assuming that local automatically means that food is produced in a more sustainable fashion. We’re going to have to tackle some of these tough questions through the regulation and how we work with the organizations involved.

At the end of the day, we really support what’s been said around the table. Education is the key. I’m noticing around the table that there are some folks my age. Recycling programs didn’t happen because we legislated recycling and then we waited till people were grown up and asked them to recycle. We went after students when they were in grade 5 and grade 6, and we introduced blue box programs.

We need to take the same approach to local food. If we are not teaching young children about food systems, we’re not looking at reports that this government has put out in 2006 and 2009 asking for a deeper connection between food and education, whether that’s school garden programs or it’s working back in home economics, we are really going to miss the boat in doing the third purpose of this act, which is creating our new market for local food, and that should be every Ontarian who understands the value of the food system.

I’m open to questions.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We’ll move to the government side: Mr. Crack.

Mr. Grant Crack: That was a lot of information.

Ms. Jodi Koberinski: I can talk quickly.

Mr. Grant Crack: You did a great job. Thank you very much. The Organic Council of Ontario: Maybe you can just tell us a little bit more about that, and how does it fall in line with how you want to promote the local food—

Ms. Jodi Koberinski: Sure. We're a full-value-chain organization. We represent everybody in the system, from producer all the way through to eater, so we really already deeply understand how a value chain works and how to represent consumer value from production all the way through to the other side.

We are really keen to see that resilience here includes environmental sustainability. So we recognize that attaching targets for how food is produced is light years ahead of where our system is at. Our engagement in this particular conversation is about creating space for defining "local" in a way that moves us along that sustainability continuum, but we don't have any illusions that we'll introduce targets that also attach an environmental goal to procurement at this point. We are hopeful, though, that down the road, when we're looking at the economic and health benefits that come from organic production, any targets we set for local will also include targets in the future for local organic and really making use of that Foodland Ontario organic designation. Does that answer your question?

Mr. Grant Crack: It sure does. It was perfect. I really appreciate what you're saying about the aspirational component of this and setting us up for the long term, not just to deal with some short-term initiatives—

Ms. Jodi Koberinski: I was just expressing to some colleagues outside how much I do appreciate these opportunities for these conversations, because if I'm talking about next quarter, everybody behind me—I'm on one extreme end of the conversation, but when we're out in the hall discussing what's going on in here, we are all very much on the same page. Whether it's Alison from pork or it's us from the organic sector, we really want to see a sustaining food production system over the long term.

Mr. Grant Crack: Okay. Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Good. Thank you very much. We'll move to the official opposition.

Mr. Ernie Hardeman: Thank you very much for your presentation. I appreciate the fact that you agree, as almost everybody presenting today has said, that we need something to aspire to.

Ms. Jodi Koberinski: Absolutely.

Mr. Ernie Hardeman: I totally agree with that. I just want to take a little different path. We've heard some debate about "local" and "local" being all Ontario and whether we should define that more. I wonder if you could tell me what it is we're trying to sell. Like, what does it mean? Why should the consumer walking on University Avenue be interested in buying local?

Ms. Jodi Koberinski: This is actually—I went deeper into this in my presentation. People choose local food

because they're rejecting the industrialization of the food system on some level. They're recognizing they no longer have a relationship with their food. Maybe they have been sick and recognize that what they put in their bodies really matters, or once they enter into the local food system and they begin to develop that relationship with a farmer at the farmers' market or with a brand on the shelf, like Organic Meadow—110 farm families, 50 cows at a time—they can really relate on that sort of personal level.

In the work that I've done over 20 years in this space, what I've really noticed is that when people are moving toward local food, they're looking for a different kind of relationship with their food than simply as a consumer. There's a recognition that what we had pursued out of the 1950s, which was a good agenda—let's not starve—created uniformity, predictability and convenience, but that those things alone are not going to satisfy what it is we really get out of food. So we think that local food is sort of the gateway drug to a more connected niche within the community itself. It opens up people's eyes to their relationship to their community. Does that answer your question?

Mr. Ernie Hardeman: So the definition of "all of Ontario" wouldn't accomplish that?

Ms. Jodi Koberinski: Where we run into issues is things get complicated. If I make a pasta, I might be able to get a local wheat, but I can't get sunflower oil. I might have to get that over the border. So does my product end up not being local?

I really appreciate Sustain Ontario's contribution to this, that we really need to think about local being regional, because sometimes "local" is across the border in Quebec, if you're in Cornwall, or sometimes it's south of the border, if you're in Windsor; right? How we get to what people are looking for in local—they're looking for a relationship with their food and they're looking for food that's produced in what they believe is a more sustaining fashion.

That's why I made the reference to the idea of proxy, because people assume that just by food not travelling, it's environmentally better. They are also assuming that their farmers are using a more respectful practice than what they've seen in the Food, Inc. videos. Clearly, in Ontario, across the board, our farmers are practising some of the cleanest agriculture. Whether they're organic or not, we want to really celebrate that, but that—

The Vice-Chair (Mr. Ted Chudleigh): Thank you.

Ms. Jodi Koberinski: We need to get at that what's behind local is the relationship, not the location.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. If we could move to the third party.

Mr. Jonah Schein: Thanks, Jodi. Thanks for coming in. I'm just trying to understand. I'm getting a sense that you're concerned about something happening here in terms of short-sightedness. Is there anything that's been presented that you see as being short-sighted so far?

Ms. Jodi Koberinski: That we could do in the short term?

Mr. Jonah Schein: No. Is there something short-sighted—like you came in by saying you want to pass the bill—

Ms. Jodi Koberinski: I want to make sure that we have an aspirational bill here. I think the resistance to setting targets or—if we just look at the act inside of the food system we have as it operates today as opposed to the kind of food system we want down the road, we're going to end up setting targets that are probably not aggressive enough. We're going to not be—

Mr. Jonah Schein: Could you not be aspirational and have targets?

Ms. Jodi Koberinski: Well, I think that you can. That's what I'm saying. We don't want to give up the aspirational side for the pursuit of the short term. I think targets are absolutely necessary. We didn't get emissions changes in California without setting targets. We're not going to get local food without setting targets. I believe that they should be incremental and that we should set aggressive targets in the 10- or 15-year term so that people can start planning into that, as opposed to constantly being in a situation where we say, "We can't find enough supply." The supply will build if they know it's coming. We were able to plan building cars with lower emissions because we set hard targets that were down the road.

Mr. Jonah Schein: In terms of paths to marketplace to support small organic farmers, you mentioned farmers' markets. Are there other things that we should be looking at in terms of—

Ms. Jodi Koberinski: Absolutely. I mean, why every hospital doesn't belong to a community-shared agriculture program or why we aren't working with some of the food hub models that are starting to come up in the institutions is a real surprise to me. I think there are lots of opportunities to work with farmers in the local community, whether it's at the school level or at the hospital level in particular.

Does that answer your question? Great.

The Vice-Chair (Mr. Ted Chudleigh): Good.

Ms. Jodi Koberinski: Thanks so much, everyone.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much for coming in and sharing your opinion.

ALLIANCE OF ONTARIO FOOD PROCESSERS

The Vice-Chair (Mr. Ted Chudleigh): We'll move now to the Alliance of Ontario Food Processors. We welcome back to the Legislature former Speaker and member Mr. Peters.

Mr. Steve Peters: Thank you, Mr. Chair.

The Vice-Chair (Mr. Ted Chudleigh): I know that you remember the day when you ejected me from the House, and I want you to know I hold no hard feelings about that today.

Mr. Steve Peters: Thank you. I trust that these interjections are not going to cut into my time there, Mr. Chair.

The Vice-Chair (Mr. Ted Chudleigh): You will be getting your full five minutes; I can assure you of that. Welcome.

Mr. Steve Peters: It's a pleasure to be back and it's a real pleasure to be sitting on the other side of the table. My name is Steve Peters, executive director of the Alliance of Ontario Food Processors. We represent about 650 food and beverage manufacturers in the province. The province is home to 3,000 companies. We are the third-largest food cluster in North America, so the food processing industry—as much as we may think the economy of Ontario drives on four wheels, we are the industry that is the engine of the economy of this province. Also, we're the important link from the farm gate to your plate. We play a very important role.

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Some of the comments that I would make regarding the purposes of the act—knowing where your food comes from: There seems to be a lot of discussion around the table about education, and that's great. I would dare not bring a prop into the Legislature, but I would encourage you to go read a label on a product over there. When we talk about education, I think one of the things we need to be looking at is education as to how to read a label. I would challenge anyone in this room: How many people could read this label? How many people might think that because this is Canada Choice, they're drinking 100% apple juice produced here in Ontario? I think part of the education needs to be an understanding of labels, an understanding of our whole food safety system. Educate the public on the great things we do here in this province and putting our system up against any other in the world.

We need to educate as well and make people understand what GMO versus non-GMO is. What is organic? What is hormone-free? A lot of things that people don't know—they think they know—to me, that's part of education, not just teaching someone how to cook. I'll always remember Miss Edgar, my home ec teacher, and what she did.

As well, when you talk about market development, one of the things we need to be conscious of is adding value, that it's not just about fresh product getting into our facilities. We need to look at how we can get more processed product into our facilities as well.

If you want to support new processors, it's not just all about money, that there are going to be funds available from the Local Food Act and Growing Forward 2. A new processor is going to need navigational tools. If somebody's going to get into a business of becoming a food processor because they can grow a great cucumber—we don't have a large cucumber processor left in this province. If you had a farmer who was growing cucumbers and his wife makes the ideal dill pickle at home, how do we educate that person to bring that product from the farmer's field to a processed product, to make it available? We need to make sure that we have the navigational tools as well.

On the question of definition of local food, one of the things we need to be conscious of, and I think the

committee needs to be conscious of, is that a lot of the food processors in our province can't source everything right here in the province of Ontario. We make some wonderful baked products. A lot of that good hard wheat is coming from western Canada, but it's supporting a small local bakery here in Ontario. Is that local?

One of my favourites: Ontario craft beer. In Ontario craft beer, we've got some amazing breweries around the province. We have very few hop producers here in the province of Ontario. The majority of the hops are coming from Washington state. Many of the barleys that are going to be used in those products are coming from western Canada. To me, the Railway City brewery in St. Thomas is a local product, producing a great local beer, but not all the hops, as I say, are going to be consumed locally. I think that's something that you need to think about in the definition as well.

The question of goals and targets: You know, I look at the Ontario food processing industry. We add value to 65% of everything that is grown or produced in the province of Ontario. It used to be 70%. To me, there's an opportunity. If we're adding value to 65%, how do we get to 70%, 75%? Because the best safety net for a farmer in this province isn't a cheque from the government of Ontario; it is having a good market to sell his or her product in.

New exports, import displacement: One of the challenges we've got in Ontario right now, and in Canada as a whole, is imported food products. We've gone from a trade deficit of \$1 billion a year to over \$5 billion a year. How do we start to displace that? The FreshCo I visited last night in Brampton is entirely different than the FreshCo that I would visit in St. Thomas. How do we take advantage of that changing face of Ontario? Again, I think we could set targets for import displacement, to look at new exports. You can do it. We did it here at the Legislature. We said, voluntarily—and Mr. Hardeman made reference to the apple issue. We were able to get to where almost 75% of everything that was sold or is sold downstairs and within this legislative dining room is an Ontario product.

Local Food Week: I'll leave that one for you to debate. Perhaps if nothing else, maybe you might want to look at a local food month.

The tax break for donations: We support this. Right now, I think you should perhaps look at getting it right with fruits and vegetables, but one of the things you should be looking at is, if you can get it right there, then start to look at food processors. Food processors are great supporters of food banks all around Ontario, but it's voluntary. Are there some incentives that we could put in place to help a food processor give more to support the local food banks through tax credits? Again, as I say, they're supportive of the industry already, and we'll watch with interest as that one moves forward, Mr. Chair.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We appreciate your comments.

We'll move to the official opposition: Mr. Hardeman.

Mr. Ernie Hardeman: Thank you very much, Mr. Chairman, and thank you very much, Mr. Speaker, for being here and making your presentation this afternoon.

I want to go to the last one at the end. I think that's the first presenter of all the presenters we've had that deals with the processing industry as it relates to the whole issue of the Local Food Act and the involvement with it. It's one thing to talk about horticulture coming in and the fresh produce, but local food could be much more than that in the processing industry. Could you just quickly tell me what part the food processing industry could play in what we're talking about here as local?

Mr. Steve Peters: Well, I think a lot of your food service providers now—not every hospital in this day and age is preparing their food in the kitchens like they used to. They're outsourcing to a co-packer or someone that's in that food service industry that is preparing a lot of that product in advance. It could be the ground beef patties and the mashed potatoes that are being served, and those maybe are being prepared off-site. There would be that opportunity for the food and beverage sector to not just—again, I don't think that this Local Food Act should just focus in on fresh product; there are ways to add value. If a local hospital is looking at a source to procure its product, then it could be a company—Marsan Foods here in Toronto as an example—that produces a lot of pre-prepared foods. I think there are opportunities to involve the processing sector going forward.

Mr. Ernie Hardeman: But in that one, if I could just go one step further, would it be possible or practical for processors—you represent a whole group of processors—if you were going to tender a request for proposal to supply that food that we're talking about, to actually include what percentage of it you wanted to be Ontario product?

Mr. Steve Peters: Very much so. I think we demonstrated that we could do it with our food service provider here at the Legislature. I know of restaurants that are out there right now that wanted to serve local, but one of the challenges they have is procuring their product. Their chef spends more time out trying to source the garlic, tomatoes, peppers and the chicken and meat and not spending that time in the kitchen. You could create almost a shopping list of product that could be available, again helping on food education, to help the food service industry or the restaurant industry, to guide them as to where to go to source the product they need to serve local.

Mr. Ernie Hardeman: Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll move to the third party.

Mr. John Vanthof: Thanks very much for coming, Steve. You've brought, I'd say, a unique perspective. As a lifelong dairy farmer, production is just one part of the chain. Often if you don't have the other parts of the chain, the production will never get to the consumer. Also with your goal, there's got to be a way that we can set something more than an aspiration—a target or a starting line. This act doesn't really even have a starting

line. That's what I think we're all looking for. Would you agree with that?

Mr. Steve Peters: Well, what I would say with the act is that I think the goal is lofty, but at the same time you've got to—and this may go back to education—make that decision as a consumer, that either as a consumer or as a provider of product we are going to do everything we can to secure local product.

Again, I will come back to this Legislature. When we said to our food service provider, “We recognize that we're a trading country and we need coffee and we need orange juice, but we want Ontario apples in here. We want you, in your menu development downstairs, to find ways to procure that product locally,” I can't answer the question: Did that cost us more? But it was voluntarily done by us saying, “Look, this building is a showcase to the province of Ontario. We want to showcase Ontario product,” and our food service provider did that.

I think there would be opportunities to find ways to work with our hospitals and our various institutions. Sometimes they just don't know—again to my comment about the restaurant, sometimes they don't know where to go. To me, I come back to education. Education is not just teaching somebody how to cook the food, but where do you go to find it?

Mr. John Vanthof: One more nuts-and-bolts issue regarding the amendment to provide a tax credit to farmers, which we agree with. I'm looking again at dairy. I provided milk to the food bank, but it only worked if the processor also provided the processing. In a case like that, a long-term goal would be some kind of tax regime for the processor as well, if it's partnering with the farmer?

1730

Mr. Steve Peters: I think there could be. I think there could be opportunities. We'll use apples. Perhaps there's an opportunity to work with an apple juice processor: You know what? We're going to send in some additional apples. The farmer gets credit for those apples. The processor then could get credit for the apple juice that is created from that product.

Mr. John Vanthof: Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Good. Thank you very much. Government? Mr. Balkissoon?

Mr. Bas Balkissoon: Steve, welcome back. Good to see you here. As you discussed the definition—and many of the others did too—you said that somewhere down the road we have to add processing. You kind of created a question in my mind. A lot of the processing is not 100% local; they have to bring some stuff from outside. But the act, the way it's written right now, is targeting the local stuff. Are you saying that right now we should look beyond that? To me, that's phase 2 and phase 3, where we look at the processors later on, unless we can clarify right now it's local food grown and processed and it has to be 100%, because the goal is to start here and later on we'll try and improve it.

The second question I have for you, and you can answer it, is the targets and whatever—definitely we can

deal with those targets or goals in regulation. Would you agree with me?

Mr. Steve Peters: I think, yes, you could deal with them in regulation, but I do think you do need to say that if we're adding 65% value, we've got to set that goal to get us to 70%.

To your first question: I'll use a samosa. We can create some amazing samosas in the province of Ontario. We could use Ontario flour, Ontario vegetables, Ontario meat, but all those spices that are required to make that amazing samosa we cannot source here in the province of Ontario. I don't know. I still think that's a pretty local product, but those spices didn't come from Ontario, so does that rule out that being local food?

Mr. Bas Balkissoon: I'm not saying it rules it out, but it would belong in a separate category.

Mr. Steve Peters: I'll leave that one for the Ministry of Agriculture and Food to figure out.

Mr. Bas Balkissoon: I'll go back to the regulation. This is the act and the act would set the framework. To me, when we create the regulations, we can go out to the industry and say how much percentage of apples it is today and then set the goal where we want to be in two years or five years or six years.

Mr. Steve Peters: I would say that as long as you're developing those regulations you are consulting on the regulations and they're not just going to be developed internally and dealt with by the legs and regs committee and then suddenly become law. This is an opportunity—if you're going to bring in regulation, this would require a great deal of consultation with industry.

Mr. Bas Balkissoon: And I don't disagree with you because I think that's the intent. Thank you.

The Vice-Chair (Mr. Ted Chudleigh): We appreciate you coming in, Steve. Good to see you again.

Mr. Steve Peters: Thank you. The Alliance of Ontario Food Processors is hosting a reception next Monday here at the Legislature. I hope you can join us.

The Vice-Chair (Mr. Ted Chudleigh): It's on my calendar.

DIETITIANS OF CANADA

The Vice-Chair (Mr. Ted Chudleigh): I'd now like to welcome the Dietitians of Canada. Thank you very much for coming in. We have five minutes for your presentation, followed by three minutes of questioning. At a minute to go, I'll give you a little tap on the counter. Would you please identify yourself for the purpose of Hansard.

Ms. Leslie Whittington-Carter: Great. Good afternoon. I'm Leslie Whittington-Carter and I'm the government relations coordinator with Dietitians of Canada. Thank you for the opportunity to speak to you today about the proposed Local Food Act.

Dietitians of Canada is a professional association for registered dietitians across the country and we have about 3,000 members here in Ontario. Our vision is to advance health through food and nutrition, so our recommenda-

tions around strengthening the Local Food Act are built on its ability to support Ontarians' health.

First recommendation: We would like to propose adding another purpose to the bill to complement the economic-awareness-raising purposes that are already in place, and that is to support healthy eating through increased food literacy and food skills, as well as access to local foods. I know you've heard a lot about food literacy and I'm going to talk a little bit more about that again. By articulating that additional purpose, you really get a potential for stronger impact on health.

To enable an added purpose of food literacy and food skills, we recommend that the Local Food Act be used to direct the Ministry of Education to work toward incorporating an evidence-informed food literacy and food skills component in mandated curriculum for K to 12. That would include things like food access, food selection, nutrition education, food preparation, cooking, budgeting.

You heard from other presenters last weekend that food can be woven across many strands of the curriculum, and we certainly agree with that. There are certainly nutrition lessons incorporated currently, but there is a lack of food literacy and food skills. Providing opportunities for all Ontario children to develop these fundamental skills through the education system will support healthy eating, and it will also contribute to the increased use of local Ontario food products.

Right now, we're in the midst of a pilot project, in collaboration with OMAFRA and the Ontario Fruit and Vegetable Growers' Association, to run a pilot for a healthy fundraising program called Fresh from the Farm. The numbers are still preliminary, but right now we've got, I believe, over 110,000 pounds of Ontario fruits and vegetables going to Ontario families through this healthy fundraising program. That's an example of how various organizations can work together to contribute to advancement of local foods.

Dietitians of Canada also supports food literacy and food skills through our Nutrition Month campaign held every year in March. In 2010, Nutrition Month focused on local foods, asking Canadians to celebrate food from field to table. Last year, consumers were guided through selecting food, making their decisions at the grocery store. This coming March, we're going to continue the food skills emphasis by talking about cooking and enjoying healthy foods together. These Nutrition Month campaigns have tremendous reach across the province and the country, and we can strengthen children's exposure to this messaging through mandated food literacy and food skills curriculum to bring about even more positive results.

Our second recommendation is to support inclusion of goals and targets for local food procurement in public sector organizations, as long as those targets are set with involvement of stakeholders and with supports to make them attainable. I'll build on some of what the previous speaker mentioned; Steve Peters was talking about processors. We also note the need for adequate process-

ing capacity for local foods to enable public sector organizations to integrate foods effectively with limited staff to prepare them from the raw state. For example, the Norfolk county Local Foods to Health Care Facilities Initiative reported some challenges for the Ontario food processors to meet the needs of the broader public sector organizations. We recognize that there is a need for some incentives and supports along there.

The final point I'll make is that I'd like to see the Local Food Act be used as a starting point for adoption of a broader food and nutrition strategy, which I believe you've also heard about from some other speakers, and which has the potential to result in health, economic and environmental gains for Ontario.

I'd be happy to answer any questions on any of those recommendations.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll start with the New Democratic Party.

Mr. Jonah Schein: Thanks for coming in. I agree with many of the points that you raised.

I'm wondering if you've heard of a study called The Cost of the Nutritious Food Basket that a public health unit has put out.

Ms. Leslie Whittington-Carter: Definitely.

Mr. Jonah Schein: For folks around the committee table, it says how much it costs for a person, by age and by sex, to eat based on the Canada Food Guide.

Ms. Leslie Whittington-Carter: Essentially, yes.

Mr. Jonah Schein: You know that it's pretty much impossible for low-income people in this province, people who are on social assistance programs, to ever come close to eating—

Ms. Leslie Whittington-Carter: The scenarios that are depicted using the Nutritious Food Basket do show that there's a shortfall, I believe, for every category—definitely for families and for single-parent households, there's a huge shortfall in terms of being able to purchase a healthy diet, as indicated through the Nutritious Food Basket.

Mr. Jonah Schein: There seems to be a tremendous reluctance by this government to ever actually address income security programs in Ontario. Would you suggest that maybe to get access to healthy food, that we actually deliver this through our school programs, that we actually put food in schools for students? Would that start to address some of these issues?

Ms. Leslie Whittington-Carter: I think food in schools is certainly one aspect of it. Our advocacy around the Nutritious Food Basket and poverty reduction has certainly been using the—we recommend using the Nutritious Food Basket data as a starting point for developing the social assistance rates and other methods of determining the supports that are needed for people to be able to attain a healthy diet.

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Mr. Jonah Schein: And one path along the way would be making sure that there are student nutrition programs—

Ms. Leslie Whittington-Carter: Student nutrition programs are an excellent example of where you can build in both education and actual food provision.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We'll move to the government. Mr. Crack.

Mr. Grant Crack: A couple of things: Welcome and thank you very much. Maybe you could just elaborate on the goals and targets that you set out. You appear to be okay with the goals and targets set with stakeholders. Would those be legislated targets, or is your opinion to have aspirational targets, where we can continue to strive to reach those in the event special circumstances prevent us from reaching them in a particular year?

Ms. Leslie Whittington-Carter: I think that the main point with anything that is legislated would then be, what is the enforcement and recourse if those targets or goals are not met? I think that again would require some very strong consultation to find out what is practical. I also think that any goals and targets need to be based on some sort of evidence. Some of the other speakers have alluded to what's happening now. We need to find out—anything from 15% to 30% are some of the numbers being used. But I definitely recommend that whatever is set as a target would be based in knowing what our starting point is.

Mr. Grant Crack: Okay. Thank you. Maybe you could just explain the position of the dietitians on the National Food Strategy. You have a minute, maybe. Are there any comments on that, on how it relates?

Ms. Leslie Whittington-Carter: We definitely believe that there is a need for a food strategy. Here in Ontario, we have been very involved with development of an Ontario food and nutrition strategy, so we would like to see, obviously, linkages between any national work and provincial work. But the work that has been done to date on an Ontario food and nutrition strategy has been the result of great collaboration between a whole host of parties from agriculture, processing, farmers and the health sector. A great deal of work has been done, and now the need is to take some of that to the next step by having that cross-ministerial and inter-sectoral approach to developing a healthy food strategy for the province.

Interruption.

The Vice-Chair (Mr. Ted Chudleigh): We apologize for the distraction. The food is so plentiful it rolls across the floor.

Ms. Leslie Whittington-Carter: I hope that was a local cookie that went across.

The Vice-Chair (Mr. Ted Chudleigh): If we could move to the Progressive Conservatives for questioning.

Interjections.

Mr. Ernie Hardeman: I won't go there, Mr. Chair-man.

Thank you very much for your presentation. I think you are the last presentation we are going to have on the Local Food Act. I think it has been almost universal, that we've had a discussion from almost every presenter

about the issue of targets and setting something to aspire to, and I think you came to that.

I did this with one other one, too; I'm going to be a little different on this one. Representing the dietitians, you talked a lot about the quality of the food and how important it was that everybody gets the right kind of foods. Why is it that that is connected to the Local Food Act? I don't see anything in the Local Food Act that tells me that there's any difference between the food that we're talking about grown in Ontario and the food grown anywhere else in the world. How do we square the circle with the fact that we're talking about local food, and the diet part of it is important in your presentation?

Ms. Leslie Whittington-Carter: Well, I think one of the most obvious intersections is around the use of local Ontario fruits and vegetables. Obviously the more fruits and vegetables you eat, it's a pretty good indicator of having a better overall, healthier diet. Certainly, there's other—meat products are also healthy choices, and there's tons of other examples of Ontario foods that are also part of a healthy diet. I'm not sure if I'm answering your question, exactly.

Mr. Ernie Hardeman: I think you're getting there. Yes, I think it is. But your explanation would suggest that we could call this bill the wholesome food act, and it would do the same thing. Is that right? From your presentation, we're talking about the quality of the food as opposed to where it's grown or where it's produced.

Ms. Leslie Whittington-Carter: I think we're also concerned with the economic and environmental benefits of local foods as opposed to merely the very important nutritional values as well. Certainly, that's where the local food does—

Mr. Ernie Hardeman: Well, I want to thank you, as the last presenter. We finally got an answer that says why it is that we have this Local Food Act. Thank you.

Ms. Leslie Whittington-Carter: Well, thank you very much for your time. I'm glad I could be the last one to wrap it up.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much for coming in. We appreciate your views.

If there's no further business to bring before the—

Interjection.

The Vice-Chair (Mr. Ted Chudleigh): We have some business?

Mr. John Vanthof: I would like to move a motion. I move that the Chair of the Standing Committee on Social Policy write to the House leaders on behalf of the committee, requesting that the committee be allowed to travel from place to place and meet at the call of the Chair during intersessions—

The Vice-Chair (Mr. Ted Chudleigh): I'm sorry. The committee is meeting today on Bill 36. Under the programming motion, that was the only thing we can discuss today.

Mr. John Vanthof: With your indulgence, Chair, could I just table it and read it into the record?

The Vice-Chair (Mr. Ted Chudleigh): No. You can table it.

Mr. John Vanthof: Then I'd like to table it.

The Vice-Chair (Mr. Ted Chudleigh): You can table it.

Mr. John Vanthof: And read it into the record?

The Vice-Chair (Mr. Ted Chudleigh): No. You can table it. You can't read it into the record.

Mr. John Vanthof: Okay.

The Vice-Chair (Mr. Ted Chudleigh): I would if I could, but I can't.

Mr. Grant Crack: Chair, can we take a five-minute recess prior to that motion coming forward?

The Vice-Chair (Mr. Ted Chudleigh): No. I overruled him. There's nothing to recess for.

I remind the committee that there's clause-by-clause on Bill 36 on Tuesday, October 29, at 4 p.m., or following orders of the day. Thank you all very much. The committee stands adjourned.

The committee adjourned at 1746.

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Mardi 29 octobre 2013

Standing Committee on Social Policy

Local Food Act, 2013

Comité permanent de la politique sociale

Loi de 2013 sur
les aliments locaux



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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 29 October 2013

Mardi 29 octobre 2013

*The committee met at 1602 in committee room 1.*LOCAL FOOD ACT, 2013
LOI DE 2013 SUR
LES ALIMENTS LOCAUX

Consideration of the following bill:

Bill 36, An Act to enact the Local Food Act, 2013 and to amend the Taxation Act, 2007 to provide for a tax credit to farmers for donating certain agricultural products that they have produced / Projet de loi 36, Loi édictant la Loi de 2013 sur les aliments locaux et modifiant la Loi de 2007 sur les impôts pour prévoir un crédit d'impôt pour les agriculteurs qui font don de certains produits agricoles qu'ils ont produits.

The Vice-Chair (Mr. Ted Chudleigh): Okay, we'll call the committee to order. We're here for Bill 36, An Act to enact the Local Food Act, 2013. We're here for clause-by-clause consideration.

Are there any general comments before we start? Seeing none, we will—apparently, it's procedure that we skip the first two, which deal with the preamble. We'll deal with those later. Like accountants, you deal with the first page last.

We'll go to section 1. Are there any amendments to section 1? Seeing none, shall section 1 carry? Carried. All in favour? Agreed.

Moving to section 2, are there any amendments to section 2?

Mr. Ernie Hardeman: I move that clause (a) of the definition of "local food" in section 2 of the bill be struck out and the following substituted:

"(a) food processed or harvested in Ontario, including forest or freshwater food, and".

The Vice-Chair (Mr. Ted Chudleigh): Sorry, Mr. Hardeman, you read the wrong word. Could you reread the amendment, please?

Mr. Robert Bailey: You said "processed."

Mr. Ernie Hardeman: Produced—"food produced or harvested in Ontario, including forest or freshwater food, and".

The Vice-Chair (Mr. Ted Chudleigh): That will suffice. Thank you.

Mr. Hardeman has moved the amendment. Is there any debate?

Mr. Grant Crack: I would just say that we would be in favour of this. It does provide more clarity with

regards to the actual wording, but in essence, we felt that the original wording had encompassed the intent as well. But we'll be supporting this.

The Vice-Chair (Mr. Ted Chudleigh): Thank you. Any other debate?

Mr. Ernie Hardeman: Just to add to that, I thank the government side for supporting. I would just point out that we had some presentations that were not actually verbally received here, but were written presentations, that had concern that without putting in the "forest or freshwater food" somehow that may not be included in the local food definition. That's why we put it in for clarification.

The Vice-Chair (Mr. Ted Chudleigh): Any further debate? Mr. Vanthof.

Mr. John Vanthof: On behalf of the third party, we would also be in favour. It provides more clarity.

The Vice-Chair (Mr. Ted Chudleigh): We're getting along very well today, aren't we? Any other debate?

All those in favour? All those opposed? Carried.

Shall section 2, as amended, carry? Agreed.

We'll move to section 3.

Any amendments to section 3? Mr. Hardeman.

Mr. Ernie Hardeman: I move that section 3 of the bill be struck out and the following substituted:

"Local Food Week

"3. The week beginning on the first Monday in June in each year is proclaimed as Local Food Week."

The Vice-Chair (Mr. Ted Chudleigh): Is there any debate to Mr. Hardman's amendment?

Mr. Ernie Hardeman: I would just point out and explain, Mr. Chairman, that this will satisfy the requests that were made by people that we separate Agriculture Week from food week. Again, we appreciate the support of the committee.

The Vice-Chair (Mr. Ted Chudleigh): All those in favour? Carried.

Any further amendments to section 3?

Mr. John Vanthof: I would like to withdraw amendment 5.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much.

Any further amendments to section 3? No further amendments?

All in favour of section 3, as amended? Carried.

The Vice-Chair (Mr. Ted Chudleigh): We'll move to section 3.1 of the bill. Amendments? Mr. Vanthof.

Mr. John Vanthof: I move that the bill be amended by adding the following section:

“Duty to buy local food

“3.1(1) When a public sector organization buys food, it shall buy local food except if the cost of doing so is more than 10 per cent higher than the cost of buying food that is not local.

“Same

“(2) For the purposes of complying with subsection (1), a public sector organization shall assess the cost of food in accordance with the regulations.”

The Vice-Chair (Mr. Ted Chudleigh): Debate?

Mr. Ernie Hardeman: Mr. Chair, I have some concerns with this, with the broadness of the motion. When we look at setting 10%, it doesn't then define any different purchases. If one of those organizations goes to buy a package of cookies, they would have to shop around to see whether, in fact, local baked cookies were going to be less than 10% more, and they'd have to buy that. I think that section is too broad.

I also believe that we would be better served if somehow we said that preference should be given for local buying but not necessarily a percentage. It should be done by regulation where the minister could set a local buying standard that would give preference to local purchases.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Mr. Crack.

Mr. Grant Crack: Mr. Chair, we won't be supporting this. We feel that prescriptive measures would create an unnecessary regulatory burden. We heard from stakeholders that they were favourable to the aspirational aspect of the bill, so we will be voting against.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Mr. Bartolucci.

Mr. Rick Bartolucci: Listen, I don't think anyone is against the intent of this particular amendment. I think the intent is very, very good. The prescriptive 10% is sort of contrary to what we already have in place. The threshold we have in place is \$25,000 for other purchasing in other ministries. I'm just wondering, by way of regulation—at some point in time, we may want to look at that.

The Vice-Chair (Mr. Ted Chudleigh): Mr. Hardeman?

Mr. Ernie Hardeman: I'm not sure this is appropriate to have the debate, but I don't believe that this would actually infringe on the \$25,000; it would just expand that. The other one has \$25,000; this one doesn't. So I believe it would be in order if it was right.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Mr. Vanthof.

Mr. John Vanthof: It may be a moot point at this time; I see we're going to lose this motion. It's just that what this motion is trying to get at is we strongly feel that when you're passing a law, it should be more than aspirational. That's what we're trying to get at. Thank you.

1610

The Vice-Chair (Mr. Ted Chudleigh): Okay. No further debate?

Shall the motion carry? All those in favour? All those opposed? The amendment is lost.

Moving on to section 4 of the bill. PC amendment, Mr. Hardeman.

Mr. Ernie Hardeman: I move that subsection 4(1) of the bill be struck out and the following substituted:

“Goals and targets

“4(1) Within 12 months after the day this subsection comes into force, the minister shall establish goals or targets in respect of local food.”

In speaking to it, I would just point out that as was just mentioned by the third party, we need more than aspiration in the bill. I think this is suggesting and trying to accomplish both what the minister wanted to accomplish and what we believe needs to be accomplished in setting goals. We think it's very important that even though we are going to build a bill around aspirations, we need something to aspire to; and recognizing that it shouldn't be arbitrarily just put in this bill, we believe that the minister “should” and not only “may” do these aspirational things, that they “shall” over time actually set the standard. There's nothing in here that says what that standard should be, but there should be something put in place in the first 12 months of the bill being put in place.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Mr. Vanthof.

Mr. John Vanthof: We are not in favour of this. Kind of a reverse argument from the last amendment, if we're going to set targets and establish goals, we should do it in debate here as opposed to leaving it off to the minister in 12 months. So we're not in favour.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Ready for the vote?

Shall the amendment carry? All those in favour? All those opposed? The amendment is lost.

Moving on, Mr. Vanthof.

Mr. John Vanthof: I move that subsection 4(1) of the bill be struck out and the following substituted:

“Goals and targets

“4(1) The minister shall, to further the purposes of this act, establish goals or targets to aspire to in respect of local food, including goals or targets to,

“(a) improve food literacy in schools;

“(b) increase access to student nutrition programs across Ontario and increase their local food content;

“(c) increase local food content in school cafeterias;

“(d) increase experiential learning opportunities for Ontario students by developing school garden programs and increasing the number and use of teaching kitchens in schools; and

“(e) reduce or streamline regulatory requirements governing the production and processing of local food with a view to encouraging increased availability of local food without significantly affecting food safety.”

The Vice-Chair (Mr. Ted Chudleigh): Could you repeat the last line again?

Mr. John Vanthof: Sure: “(e) reduce or streamline regulatory requirements governing the production and

processing of local food with a view to encouraging increased availability of local food without negatively affecting food safety.”

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Debate? Do you have an opening statement on this?

Mr. John Vanthof: An opening statement? Like a—

The Vice-Chair (Mr. Ted Chudleigh): Any debate?

Mr. John Vanthof: Sure, sure. Basically what we’re trying to do here is, we’re not trying to restrict—because the minister could set more goals than this. We’re not restricting it to these goals, but we’re trying to set a direction of what we think should be—if it’s going to be aspirational, here’s a few things we think you could start with. We’re not trying to limit it to these five. It could be more, it could be different ones, but here’s some direction where we could go.

The Vice-Chair (Mr. Ted Chudleigh): Thank you. Further debate?

Mr. Grant Crack: We won’t be supporting this particular amendment. We feel that it’s far too prescriptive and limits our options in the future. As such, we’ll be introducing the next amendment, which I think deals with food literacy. We have recognized the need to deal with that important issue as we move forward.

The Vice-Chair (Mr. Ted Chudleigh): Thank you. Further debate?

Mr. Ernie Hardeman: Mr. Chairman, I have concerns with this motion somewhat, as it encompasses more than I believe it should as to what avenues the minister should be obligated to go to. Having said that, I also think that there is—we heard the comments on the last motion, on the timeline to set standards. It seems to me that this one doesn’t include any of that, so in fact she “shall” do it, but it doesn’t say whether it should be this generation or the next generation. I don’t believe it necessarily accomplishes what’s intended.

Having said that, I’d go for the one word: the minister “shall.” I think that, if there’s one thing this bill lacks a lot of, it’s what we shall do. It’s a lot of aspiration and getting very little done. If it wasn’t for the fact that we were locked into voting on what’s before us as opposed to changing motions, I would think a slight amendment to reduce some of the restriction of the directive approach of this one and this would likely be a very supportable motion.

I’m going to support it anyway, because I do believe we need to have more things to do, but I am concerned about the amount of red tape it will create. I would hope that, if it passes and is implemented, they could avoid forcing things upon people.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Mr. Vanthof?

Mr. John Vanthof: One thing: We’re trying to reduce red tape with some of this motion. Also, we tried to pick out some of the things that really resonated during the hearings, what the people who came to these hearings thought had an impact on this process, and we were

trying to give them an impact on this process. Thank you, Chair.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? All in favour of the motion? Opposed?

It being a tie vote, I will cast my lot to preserving the status quo and vote against the bill.

The Clerk of the Committee (Mr. William Short): The motion.

The Vice-Chair (Mr. Ted Chudleigh): I vote against the motion. The bill, I like.

Further motions? Further amendments? The government motion? Mr. Crack?

Mr. Grant Crack: Thank you, Mr. Chair. I move that subsection 4(1) of the bill be struck out and the following substituted:

“Goals and targets

“4(1) The minister shall, to further the purposes of the act, establish goals or targets to aspire to in the following areas:

“1. Improving food literacy in respect of local food.

“2. Encouraging increased use of local food by public sector organizations.

“3. Increasing access to local food.

“Timing

“(1.1) Each goal or target shall be established within one year after the day the relevant paragraph in subsection (1) comes into force.

“Additional goals

“(1.2) The minister may, to further the purposes of the act, establish additional goals or targets to aspire to in respect of local food.”

The Vice-Chair (Mr. Ted Chudleigh): Any debate?

Mr. Ernie Hardeman: I will be supporting this motion. Just a couple of comments on it: As I said in the earlier motion, the one thing that I liked about the motion was that it included the word “shall.” This one does include the word “shall,” so I commend the government for putting that in.

Also, “improving food literacy in respect of local food” and encouraging the use of—they “shall” do that. The other thing is, in “Timing,” it actually puts in what we had in our previous motion, which was that we establish a time frame of when the minister shall come out with these goals and directions, so I support that.

1620

The only thing I could say on it is that I wish the last one, the additional goals, also included the word “shall.” I think that would, again, make the motion stronger and better. It still wouldn’t necessarily mandate which ones it would be but that we would see more progress as time went on, so I think we would have been better off with that. But, having said that, we will be supporting this motion, Mr. Chair.

The Vice-Chair (Mr. Ted Chudleigh): Mr. Vanthof.

Mr. John Vanthof: We will also be supporting this motion, but I would like to put it on the record that the people would be much better served—we’ve seen three motions that each had very good parts to them, but because we’re under a programming motion, we as a com-

mittee are unable to actually do what a committee is supposed to be doing, and that's putting our heads together and making this better legislation. That is a bit of a travesty to democracy. I'd just like to put that on the record, that under normal circumstances this committee could have combined the best and made this better legislation. We will be supporting this, but we could have made it much better.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Mr. Crack.

Mr. Grant Crack: I think, to echo my colleague from the PCs, the word "shall" does strengthen this up, as opposed to the word "may," and we think that setting clear time frames and goals for implementation indicates that we listened to all the stakeholders, and our colleagues as well, in moving this forward. It was a theme that we had heard through the two days of public hearings, that we strengthen that up a little bit—a little bit more prescriptive, I guess.

The Vice-Chair (Mr. Ted Chudleigh): Thank you. There being no further debate, shall this—oh, there is some debate? Oh, you're going to vote.

All in favour? Opposed? Carried.

Shall section 4, as amended, carry? Carried.

Shall section 5 carry? Carried.

Section 6: NDP motion.

Mr. John Vanthof: I move that subsection 6(1) of the bill be amended by striking out "At least once every three years, the minister shall prepare a report that, in respect of the reporting period" in the portion before clause (a) and substituting "The minister shall prepare an annual report that".

A short opener: I think three years is too long a period. Most government business and most of the organizations we'll be dealing with run on an annual calendar, and I think it puts more responsibility on the minister to also report annually. In three years, a lot of people will have forgotten what the original intent was.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Mr. Bartolucci.

Mr. Rick Bartolucci: We'll be supporting this. We agree that there is an accountability factor in all of this, and it can be a valuable tool in evaluation and as we move forward, so we see this as being a very, very good motion.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Mr. Hardeman?

Mr. Ernie Hardeman: No.

The Vice-Chair (Mr. Ted Chudleigh): Thank you, Mr. Hardeman.

All in favour of the amendment? Carried.

Shall section 6, as amended, carry? Carried.

Further amendments? Section 7: Mr. Vanthof.

Interjection.

The Vice-Chair (Mr. Ted Chudleigh): Motion number 6 did not carry; therefore, this one is out of order.

Mr. John Vanthof: I was about to withdraw it, Mr. Chair, to save you some trouble.

The Vice-Chair (Mr. Ted Chudleigh): It would have been easier if I had kept my mouth shut, wouldn't it?

Mr. John Vanthof: We would have been done by now.

The Vice-Chair (Mr. Ted Chudleigh): Shall section 7 carry? All those in favour? Carried. Section 7 carries.

Now we're moving to amendment number 12. It requires unanimous consent. It's a PC motion. Mr. Hardeman.

Mr. Ernie Hardeman: I ask for unanimous consent to present this motion.

The Vice-Chair (Mr. Ted Chudleigh): Is there unanimous consent for this motion?

Mr. Grant Crack: No.

The Vice-Chair (Mr. Ted Chudleigh): No, there is not.

Amendment 13—and I believe, Mr. Hardeman, you want to move amendment 14 first?

Mr. Ernie Hardeman: Mr. Chairman, I would just ask that—in the list of amendments, they put the inappropriate one first—we do the 14 before we do the 13. I would ask my colleague Mr. Bailey to—

The Vice-Chair (Mr. Ted Chudleigh): That's fine. We need unanimous consent to move this amendment. Agreed? Agreed.

Number 14.

Mr. Robert Bailey: I move that the bill be amended by adding the following section:

"Taxation Act, 2007

"7.3(1) Subsection 16(2) of the Taxation Act, 2007 is amended by striking out 'sections 17 to 22' at the end and substituting 'sections 17 to 22 and 103.1.2'.

"(2) The act is amended by adding the following part:

""Part IV.0.1

""Non-refundable tax credits

""Community food program donation tax credit for farmers

""103.1.2(1) In this section,

"""agricultural product" has the meaning prescribed by the regulations; ("produit agricole")

"""eligible community food program" means a person or entity that,

""(a) is engaged in the distribution of food to the public without charge in Ontario, including as a food bank,

""(b) is registered as a charity under the Federal Act, and

""(c) satisfies the other conditions that are prescribed by the regulations; ("programme alimentaire communautaire admissible")

"""eligible person" means,

""(a) an individual who carries on the business of farming in Ontario or his or her spouse or common-law partner, or

""(b) a corporation that carries on the business of farming in Ontario. ("personne admissible")

""Qualifying donation

""(2) A donation is a qualifying donation for a taxation year if both of the following criteria are met:

“1. The donation is a donation of one or more agricultural products produced in Ontario by an eligible person and is donated by an eligible person to an eligible community food program in Ontario.

“2. The donation is made on or after January 1, 2014.

“Amount of the tax credit, individuals

“(3) An eligible person who is an individual and who was resident in Ontario on the last day of a taxation year ending after the date prescribed by the Minister of Finance may deduct from the amount of tax otherwise payable for the year under division B of part II a community food program donation tax credit not exceeding the amount calculated using the formula,

“A x B

“in which,

““A” is the sum of the fair market value of each qualifying donation, the fair market value of which was used in calculating the amount deducted by the individual under subsection 9(21) in computing the amount of his or her tax payable for the year under division B of part II, and

““B” is 25 per cent.

“Amount of the tax credit, corporations

“(4) An eligible person that is a corporation may deduct from the amount of tax otherwise payable for the year under division B of part III, for a taxation year ending after the date prescribed by the Minister of Finance, a community food program donation tax credit not exceeding the amount calculated using the formula,

“C x D

“in which,

““C” is that part of the person’s qualifying donations for the year that was deducted by the person under subsection 110.1(1) of the Federal Act in computing the person’s taxable income for the year, and

““D” is 25 per cent.

“Trusts

“(5) A trust is not entitled to a tax credit under this section.

“Regulations

“(6) The Lieutenant Governor in Council may make regulations prescribing any rules the Lieutenant Governor in Council considers necessary or advisable for the purposes of the proper administration of the credit under this section.”

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Debate? Mr. Bailey?

Mr. Robert Bailey: I’ll let Mr. Hardeman speak to the bill.

1630

The Vice-Chair (Mr. Ted Chudleigh): Mr. Hardeman?

Mr. Ernie Hardeman: I’m just going to say this is what was the private member’s bill that Mr. Bailey put forward in the Legislature, that was supported unanimously by the Legislature. It has been worked over both with the Ministry of Agriculture and Food in Ontario and also with the federal department, to make sure it complies with the taxation rules.

First of all, I want to thank Bob for putting this motion forward in the first place. I think it makes a very strong contribution to this act.

I just wanted to quickly touch on the 14 and 13. The original one was the 13 one, which was just that the title was a food bank tax credit and we changed it in number 14 to make sure. If you look at the description of a food bank in the definitions, it includes other forms, but it really doesn’t say so.

We had presentations to our committee that said we had to make sure it applied to school food programs or local soup kitchens and so forth, so that donating it there, you could get the same tax credit. So we just changed the title in number 4, and the one we’re debating now was to the other one.

The reason that we wanted to do this one first: If all else fails with this one, we want to make sure we don’t lose sight of the fact that what we’re looking for is a food tax credit for people who donate to the food banks and to other organizations.

With that, I think if there are any questions, we’d be most happy to answer them.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Mr. Schein.

Mr. Jonah Schein: Thank you. We’ll be supporting this amendment. I am happy that it has expanded beyond merely food banks. I do think, overall, it’s a good intention.

However, I think it’s very problematic that, as a province, we’ve steered away from actually delivering adequate income security programs, adequate welfare benefits, adequate ODSP benefits, adequate wages in this province, adequate childcare, and that we’re falling back on the tax, on this kind of band-aid solution.

So the intent is good, and I hope it provides some relief to people in this province, but it’s a sorry state of affairs that we’re in this position.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Mr. Crack.

Mr. Grant Crack: Thank you, Mr. Chair, and I’d like to thank Mr. Bailey for reading that very long motion and giving Mr. Hardeman a break. That was very well done.

I can say that we will be supportive of this motion, this amendment, just to confirm our commitment to supporting our agricultural community, our farmers, and recognizing the good work that they do and have been doing in the past. If this could be of help to them in the future, we’ll certainly support that.

I can say that the Ministry of Finance also was very pleased to be able to work and fine-tune this particular amendment to make it workable. Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Further debate?

Mr. Robert Bailey: I’d like to comment, just to thank the members for their consideration. I know that the food banks and the farm community out there are going to thank all the members of all three parties who support this. So thank you again for your support today.

Mr. Ernie Hardeman: Just for the sake of consistency, or non-consistency, I'd like to ask for a recorded vote, Mr. Chair.

The Vice-Chair (Mr. Ted Chudleigh): Shall the amendment carry?

Ayes

Bailey, Balkissoon, Bartolucci, Crack, Fraser, Hardeman, Schein, Vanthof.

The Vice-Chair (Mr. Ted Chudleigh): All those opposed? Seeing none, the amendment passes.

Would someone like to withdraw amendment 13?

Mr. Ernie Hardeman: Yes, we withdraw 13.

The Vice-Chair (Mr. Ted Chudleigh): Thank you.

Mr. Ernie Hardeman: We withdraw, Mr. Chairman, the other one, since we renumbered them.

The Vice-Chair (Mr. Ted Chudleigh): We know the one you mean.

We're at amendment 15. Mr. Vanthof.

Mr. John Vanthof: Yes.

The Vice-Chair (Mr. Ted Chudleigh): This requires unanimous consent to be introduced.

Mr. John Vanthof: Okay. Do we have to ask for unanimous consent before—

The Vice-Chair (Mr. Ted Chudleigh): Do we have unanimous consent?

Mr. Grant Crack: No.

The Vice-Chair (Mr. Ted Chudleigh): Section 7—
Interjections.

The Vice-Chair (Mr. Ted Chudleigh): Shall section 8 carry? All those in favour? Carried.

Section 9: Should section 9 carry? Carried.

Now we're going back to the preamble. Number 1 is out of order because the motion that it depended on failed. We'll move to amendment number 2, which needs unanimous consent to be introduced.

Mr. John Vanthof: We would like to withdraw number 2.

The Vice-Chair (Mr. Ted Chudleigh): Withdraw number 2. Thank you very much.

Shall the preamble carry? Carried.

Just a moment. We'll get our paperwork caught up. Number 16 is out of order. It will be withdrawn.

Amendment 17: Mr. Hardeman, would you move it?

Mr. Ernie Hardeman: Yes, it's the long title. I move that the long title of the bill be amended by adding "and to amend the Taxation Act, 2007 to provide for a tax credit to farmers for donating certain agricultural products that they have produced" at the end.

The Vice-Chair (Mr. Ted Chudleigh): Debate?

Mr. Ernie Hardeman: The reason for the need of it is, because of the tax credit motion that opens the finance bill, we need to put that in the long title to make sure that we recognize it.

The Vice-Chair (Mr. Ted Chudleigh): Further debate? Seeing none, will the amendment carry? Carried.

Number 18 is out of order. Number 19 is also out of order.

Shall the title of the bill, as amended, carry? All in favour? Carried.

Shall Bill 36, as amended, carry? Carried.

Shall I report the bill, as amended, to the House on Wednesday? Carried.

Mr. Ernie Hardeman: Yes, as quickly as possible.

The Vice-Chair (Mr. Ted Chudleigh): Will Thursday do?

Mr. Ernie Hardeman: Tomorrow.

The Vice-Chair (Mr. Ted Chudleigh): Tomorrow. Okay, I'll do that. For this committee, I'll do that.

I'm sad to say that we're done here today. I was having such a good time. The committee is adjourned.

The committee adjourned at 1638.

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Monday 18 November 2013

Journal des débats (Hansard)

Lundi 18 novembre 2013

Standing Committee on Social Policy

Local Health System
Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur l'intégration
du système de santé local



Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 18 November 2013

Lundi 18 novembre 2013

*The committee met at 1401 in committee room 1.*LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): We'll call the meeting of the Standing Committee on Social Policy to order. We're here meeting today for a review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act.

SUBCOMMITTEE REPORT

The Chair (Mr. Ernie Hardeman): The first item of business: Obviously we are here and directed by the Legislative Assembly to be here, and a programming motion was passed for us. Your subcommittee has met in order to set up the meeting for today, and we have Ms. Jaczek to bring in the report of the subcommittee.

Ms. Helena Jaczek: Thank you, Chair. Your subcommittee met on Tuesday, November 12, 2013, to consider the method of proceeding on the order of the House dated November 7, 2013, in relation to the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act, and recommends the following:

(1) That the committee meet on Monday, November 18, 2013, to receive a technical briefing from staff of the Ministry of Health and Long-Term Care, pursuant to the order of the House dated November 7, 2013.

(2) That the committee Clerk invite the deputy minister, along with other staff responsible, to provide the briefing and answer questions from committee members (up to one hour for a statement and the remaining time for questions).

(3) That ministry legal staff be offered one hour to provide an explanation of the act and answer questions from committee members during the briefing (up to 20 minutes for a statement and 40 minutes for questions).

(4) That the committee meet on Monday, November 25, 2013, to continue the review.

(5) That the subcommittee or full committee meet at future dates to further discuss how to proceed on the review.

The Chair (Mr. Ernie Hardeman): You've heard the report of the subcommittee. Discussion?

For clarification, I would point out that item number 2 in the subcommittee report should be number 3 and item

number 3 should be number 2. To make sure that we have the appropriate item: Item 2 suggests that the remaining time should be allotted for questions. If you leave it at number 2 and do that first, that would not give you the opportunity necessarily to do number 3. So they should be turned around within the report. There's nothing wrong with the words—just make sure we all understand the direction there.

No further discussion on the report?

If we could just suggest that the cameras can't take pictures of the thing on the desk. If you would stay behind the chairs where the presenters are. If that's not adhered to, then you have to stay outside the door.

With that, if there's no further discussion, all those in favour of accepting the subcommittee report? Opposed, if any? The motion is carried. That is accepted, then—the subcommittee report.

MINISTRY OF HEALTH
AND LONG-TERM CARE

The Chair (Mr. Ernie Hardeman): As related in the subcommittee report, our first delegation will be the Ministry of Health and Long-Term Care: Robert Maisey, legal counsel group leader; and Kathryn McCulloch, director, LHIN liaison branch, health systems accountability and performance division. If you will take your seat there—thank you very much.

As to the report, your presentation will be an hour. We'll have approximately 20 minutes for you to make the presentation, and then the other 40 minutes will be divided equally among the parties for questions of your presentation.

With that, we thank you very much for coming in today, and we will turn the meeting over to you to make your presentation.

Mr. Robert Maisey: Thank you very much, Mr. Chair and members of the committee.

My name is Robert Maisey, and I'm legal counsel with the Ministry of Health and Long-Term Care. With me is Kathryn McCulloch, director of the LHIN liaison branch at the Ministry of Health. We are pleased to provide the committee with a technical briefing of the Local Health System Integration Act, 2006, which I will refer to simply by the acronym LHSIA, or "the act."

You should have, Mr. Chair, a copy of the presentation that I was going to speak to, which I hope has been handed out.

I'm getting a lot of echoing in my ears from the microphone.

Interjection: It's the camera.

Mr. Robert Maisey: Oh, it's the camera. Okay. Maybe if I sit back a little it'll go away.

The Chair (Mr. Ernie Hardeman): I think it's the camera broadcasting, or taping—are you taping the sound?

Interjection.

The Chair (Mr. Ernie Hardeman): Well then you'll have to stand back because there's too much echoing in our sound system.

We'll try it again.

Mr. Robert Maisey: All right. Thank you very much. I'll start at slide 3, if I may, which is the background of the legislation.

LHINs were incorporated first in June 2005, under the Corporations Act, as not-for-profit corporations. On November 24, 2005, the government introduced Bill 36, as it was then called, the Local Health System Integration Act. The Standing Committee on Social Policy conducted a clause-by-clause review and a number of public hearings, including amendments being passed which were recommended to the Legislative Assembly. On March 28, 2006, the Local Health System Integration Act was passed and received royal assent.

Slide 4 lays out at a very high level the structure of the legislation. There is a preamble, which I'll speak to in a minute. Part I lays out an interpretive section and some definitions. Part II deals with the local health integration networks as corporations. Part III speaks to functions about planning and community engagement. Part IV deals with funding and accountability within the local health system. Part V deals with integration and devolution. Part VI contains some general provisions.

In addition, there have been regulations made under the legislation dealing with committees of the board—that's the board of the local health integration networks—engagement with francophone communities, exemptions from the legislation, the French Language Health Services Advisory Council, and there's also a general regulation. This presentation will touch on each of those regulations, and it will touch on each section within the statute without necessarily going into significant detail.

I can take you, then, to slide 5. Slide 5 deals with the preamble and one of the key clauses in part I of the act, which is the purpose clause. The preamble lays out a number of principles about the health care system, including principles related to the Canada Health Act, promoting the delivery of the health system by non-profit organizations and achieving an integrated health system.

The purpose of the statute is set out in section 1. I've quoted from it there. It is "to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care in local health systems and across the province and effective and efficient management of the

health system at the local level by local health integration networks."

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If I can move to the next slide, slide number 6, one of the key defined terms in the statute is set out in section 2, and that is the term "health service provider." This is a key term because it lists the types of health service providers that are most affected by the statute. Health service providers for LHSIA are: hospitals, both public and private hospitals; long-term-care homes; community care access centres; community service providers; community health centres; and community mental health and addiction service providers.

One of the subsections in section 2—subsection 2(3)—provides that physicians, podiatrists, dentists and optometrists are not health service providers when they offer those professional services to individuals. This has the effect of taking the ministry's Ontario Health Insurance Plan outside of the LHIN system, so that payments to physicians are not within the jurisdiction of LHINs. This point will come up a couple of other times in the statute, so that's why I've highlighted that for you.

Moving to slide 7, we get into part II of the act, which is about local health integration networks as corporations, as government agencies. LHINs were first incorporated in 2005, and section 3 of the statute continues those corporations under LHSIA.

Section 4 goes on to provide that LHINs are crown agencies. The purposes or the objects of the LHINs are set out in section 5, and those are listed in an appendix to this presentation for ease of reference.

Section 6 deals with the corporate powers of LHINs, and it provides that LHINs have the capacity to function as a natural person, which means that they can contract as any other person can, but it then places some restrictions on LHINs. Those restrictions are set out on slide number 7.

The first five bullet points under that provision on slide 7 are about financial restrictions on LHINs: the inability of LHINs to buy and dispose of real estate; to lend; to invest money; and to indemnify people without cabinet approval. The last bullet deals with: LHINs are not permitted, without cabinet approval, to provide direct health services to people.

Moving to slide 8, I've tried to summarize some of the provisions related to the corporate structure of LHINs. Each LHIN has a board of directors that is appointed by cabinet, each member for up to three years, and for no more than one term renewal; that means, no more than six years. Then there are provisions around the board's structure, around remuneration, quorum, and the appointment of chairs and vice-chairs. The statute puts the affairs under the control of the board of directors. It requires board meetings to be open to the public, with some exceptions, as set out in section 9. The statute also permits the board to employ a chief executive officer and other employees, and for the minister to fix salary ranges for the CEO. Each LHIN is required to have an annual audit and to submit an annual report to the minister, and

the statute also provides that the Auditor General may audit a LHIN.

Moving to slide 9, this takes us into the subject of planning and community engagement within the statute. Section 14 of LHSIA provides that there are some obligations on the minister: to develop a provincial strategic plan; to establish some councils related to aboriginal and First Nations people and francophone Ontarians; and to seek advice from mandated province-wide planning organizations in developing the provincial plan.

Slide 10 discusses some of the obligations on LHINs with respect to integrated health service plans. Each LHIN is required to develop an integrated health service plan for its geographic area. Section 15 also describes some of the content of an integrated health service plan, or an IHSP, as it's called in short. It must include a vision, priorities and strategic directions for the health service, the local health system. It has to be consistent with the provincial strategic plan and the funding for LHINs. This legislation has been implemented so that each IHSP of a LHIN is for three years, and the current plans are from 2013 to 2016.

On slide 11, this describes some further obligations related to community engagement. A LHIN must engage on an ongoing basis with its community about the needs and priorities of the local health system, including with patients, health service providers and employees. Community engagement can include community meetings, focus group meetings or establishing advisory committees.

Each LHIN is required to engage with the aboriginal and First Nations health planning entity and French-language health planning entity that is prescribed for the LHIN. Each LHIN must also establish a Health Professionals Advisory Committee, to act in an advisory capacity, from members prescribed in the regulation.

In addition, on page 11, the last bullet deals with an obligation on health service providers. Health service providers are required to engage the community when they develop plans and set priorities for the delivery of health services in the local health system.

Moving on to slide 12, we change subjects and get into part IV of the statute, dealing with funding and accountability. Section 17 is the provision that permits the minister to provide funding to LHINs. It also permits the minister to adjust the funding of a LHIN to take into account a portion of any savings that a LHIN generates through efficiencies in the local health system.

When the minister provides funding to a LHIN, the minister and the LHIN are required by section 18 to enter into an accountability agreement. The statute sets out some of the required content for an accountability agreement. This includes performance goals and objectives of a LHIN; performance standards, targets and measures; reporting by a LHIN; the spending plan; and a progressive performance management process.

Section 19 provides the authority for a LHIN to provide funding to a health service provider. That funding has to be provided in accordance with the agreement

that a LHIN has with the Ministry of Health under section 18.

The section also goes on to provide that LHINs have to enter into accountability agreements, called service accountability agreements, with health service providers. The process for that is set out in a different statute, which is part III of the Commitment to the Future of Medicare Act, 2004. In appendix E of this presentation, I provide some additional information around that statute.

On slide 13, there are some additional provisions around accountability, auditing and information. Accountability agreements between the ministry and LHINs, and service accountability agreements between LHINs and health service providers, must be made public. The agreement between the ministry and health service providers can be assigned to LHINs under section 19. That was a transition provision to allow the ministry to move funding agreements from the ministry to LHINs, as LHINs have taken on funding authority over the last seven and a half years.

LHINs are not permitted, by section 20, to enter into any agreement that would limit a patient from receiving health care in the LHIN geographic area. There is an exception to that, which is around CCAC services. The intention with that provision is to permit patients to receive services from any health service provider, regardless of which LHIN the patient resides in. The exception to that is CCAC services for home care.

LHINs can audit health service providers that they fund, and they can require information from them. They cannot require personal health information to be provided. LHINs can also share information—financial information or performance information, for example—that they receive from health service providers with one another, with the ministry and also with the Ontario Health Quality Council.

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Moving to slide 14, here we get into part V of the statute on integration and devolution. This part is more complex than the other parts. In previous sections, we typically were dealing with only one subject, and they were relatively self-contained. In this part, a number of the provisions work together with one another, and there are quite a few cross-references.

LHINs and service providers are required to develop integration strategies to better coordinate health care services and use health resources more efficiently. The term “integrate” is defined in section 2—so that's part I of the act—to include:

- the coordination of services and interactions between persons and entities;
- the partnering with another person or entity in providing services;
- the transfer or merging or the amalgamation of operations or health service providers;
- to start or cease providing services; and
- to cease operating or to dissolve or to wind up the operations of a person.

Section 25 sets out a number of different things that are important to deal with in integration, and it's a somewhat complex section. At a high level, it does two things. It first describes the way in which LHINs can integrate within the health care system. It also describes certain requirements for LHIN integration and what has to be included in a LHIN integration decision.

In terms of the description of the ways that LHINs can integrate, section 25, subsection 1, sets out three ways: one is through funding, which is section 19; the second is the facilitation and negotiation of integration with health service providers, and that's section 25. Then, LHINs can also order integration under section 26, or they can stop integration under section 27.

As I mentioned, the balance of section 25 goes on to describe what has to be included in a LHIN integration decision in terms of things like effective dates, the requirement to give notice to the parties and the requirement to make integration decisions public.

Slide 15 deals with section 26 of LHSIA, and this is a LHIN-ordered integration, an integration which occurs without the consent of the provider. A LHIN is permitted to require a health service provider to do certain kinds of integrations. This would include providing a service, to cease providing a service, to provide a service to a certain level, to transfer a service from one location to another, to transfer all or part of a service from one person to another person, and then, generally, to make orders to give effect to any of the above.

Section 26, however, sets out a number of restrictions on the ability of a LHIN to order integration under this section. First, only health service providers that receive funding from the LHIN can be required to integrate services under section 26, and only then in relation to those services that are funded by a LHIN.

The LHIN cannot require health service providers to make corporate or governance changes under this section, and they cannot require a health service provider to completely stop all of its operations. A LHIN cannot unjustifiably require a health service provider that is a religious organization to provide a service that is contrary to that religion. Also, LHINs cannot require the transfer of charitable property to a provider that is not a charity under this section.

On slide 16, the first bullet deals with section 27. Health service providers can initiate their own types of integration activities without permission—or I should say without being required to do so by a LHIN. If they do so, however, they have to first provide notice to the LHIN that they receive funding from. The LHIN can propose to stop the integration. The LHIN has to make that decision public and the LHIN has to invite submissions about why the integration should proceed or why it should not proceed.

Section 28 goes on to provide certain powers to the minister. On the advice of a LHIN, the minister can require a health service provider to cease operating, to amalgamate with another health service provider or to transfer its operations to another entity. There are certain

restrictions on the authority of the minister under section 28 related to municipal governments and long-term-care homes, and the minister cannot order a not-for-profit health service provider to amalgamate or transfer assets to a for-profit health service provider. I should also point out that section 25, related to the content of what has to be in a minister's order, also applies to section 28.

On slide 17 there is a description of the process by which the LHIN or the minister can issue an order under section 26 or section 28, and these are the provisions where one would assume that the decisions are being made without the consent of the health service provider. In those circumstances, there's a 30-day prior notice process. There's a process for submissions to be made on a proposed decision or order and a requirement for the LHIN or the minister to consider those decisions before a final decision or order is made.

If we move to slide 18, the first four bullets deal with the implementation of LHIN integration decisions and ministerial orders on integration. The first bullet is about section 29, which is a requirement that health service providers comply with LHIN and minister integration decisions.

Section 30 deals with charitable property. If a property held for a charitable purpose has to be transferred, then the charitable purpose of the property is deemed to transfer to the entity receiving the property.

Section 31 deals with compensation. The person from whom property is transferred is not entitled to compensation except in accordance with regulations and then only for the value of the property that was not acquired from government funding.

The next bullet deals with labour relations consequences of an integration where there is an integration about the transfer of a service, or all or substantially all of the operations of a health service provider, or the amalgamation of employers—that the Public Sector Labour Relations Transition Act of 1997 applies to that integration.

Section 33 deals with the regulation-making power. Cabinet may order one or more persons who operate a public hospital and the University of Ottawa Heart Institute to cease providing a non-clinical service and to integrate the service by transferring it to a person named in a regulation.

On slide 19 we deal with the issue of devolution. This provision allows cabinet, by regulation, to devolve any power, duty or function of the minister or a person appointed by the minister or cabinet to a LHIN. This power does not apply with respect to funding related to physicians and other certain health providers. For example, it would not allow the transfer of functions under the Ontario Health Insurance Plan away from the Ministry of Health to a LHIN.

Slide 20 deals with part VI of the act, which is the general provision.

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Section 35 provides immunity from civil proceedings, except for judicial review, against a LHIN, the minister,

and their staff for decisions that were taken under the statute in good faith.

Section 36 goes on to provide a number of documents that are referred to in the act that must be posted on the websites of the minister or each LHIN.

Section 37 sets out regulation-making authority for cabinet.

Section 38 provides that before a regulation is made, public consultation must occur.

Then section 39, as you know, provides for the review of this legislation.

Mr. Chair, I'm conscious that I have already used up my 20 minutes, I think, and I haven't touched on the regulations, so—

The Chair (Mr. Ernie Hardeman): I was just going to say that we thank you very much for the thorough report, and I thought rather than cut it off at the 20 minutes, the committee would be very appreciative of hearing the whole report.

We will now start with the discussion, and I'm sure the rest of the information that we would like will come out in the discussion. We will still have the 40 minutes that we will divide equally among the three parties, so the whole process will last just a little bit longer. I think we'll start with the official opposition in questioning, and it will be approximately 13 minutes for each caucus. The Clerk will keep track of the time exactly.

With that, Mrs. McKenna?

Mrs. Jane McKenna: Thank you so much, Mr. Maisey, for your presentation. I have a few questions for you.

Right in the start-off, on page 5, you have in there “to provide for an integrated health system to improve the health of Ontarians through better access to high-quality health services.” My first question is, what are you measuring that against? Where are the evidence-based outcomes that you're actually doing that?

Mr. Robert Maisey: I think the answer to that is that this is supposed to be set out in the accountability agreement between the minister and the LHIN, which would be section 18. Then the LHIN, when it enters into service accountability agreements with health service providers, would have those kinds of indicators. Those would be set out in the funding agreement between the LHIN and the health service provider.

Mrs. Jane McKenna: I guess, if you have this act in 2006 stating that you're going to offer a high-quality service, you must be measuring it against something else. I hear what you're saying, that it's in section 18, but is that not an easy question to answer, what they're measuring themselves against?

Ms. Kathryn McCulloch: To Robert's comment, we do have performance agreements that list a number of indicators. There are 15 indicators in the current ministry-LHIN performance agreement.

We established baselines for those at the time that the LHINs came into power or took their authority, and we have been tracking against those baselines to determine the improvement or performance towards achieving improvement on those indicators.

Mrs. Jane McKenna: So can we see those?

Ms. Kathryn McCulloch: Certainly.

Mrs. Jane McKenna: Okay, and how are they doing? As far as performance measures, which LHINs would be doing better than others, and where is the improvement on the performance of one to the next?

Ms. Kathryn McCulloch: Provincially, we have improved performance, and these are posted. These are one of the documents that are required to be posted publicly on the LHIN's website. You can look at each individual LHIN's accountability agreement to see where they're at. We do have the wait time indicators that are publicly posted as well. We have been tracking those since the initial, first agreement for the LHINs. Those are wait times for hip, knee, cataract surgeries etc.

From a provincial perspective, we have improved. There is varying performance and varying improvement, but we have improved on all of those.

LHIN by LHIN, that does vary. One of the things you have to realize is that when the LHINs took their authority, they were at different places at that point in time. Some of them would have been fairly close to meeting the provincial targets that we had established, and others were considerably farther away, depending on a lot of historic factors: capacity in their system etc. So you're right: There is variation or variability across LHINs as to the performance on the various indicators.

Mrs. Jane McKenna: So what happens? Let's say one LHIN—

Interruption.

Mrs. Jane McKenna: Why are we echoing like crazy?

Interjection.

Mrs. Jane McKenna: Let's say that one LHIN wasn't performing as well as the next LHIN. Clearly, you must have something for them to follow so they know what their job description is and what your expectations of them are, or how would they measure that? But let's say one isn't performing to the standards, because you just mentioned that each one was at a different level. What happens in the case that their performance level isn't matched? What do you do there?

Ms. Kathryn McCulloch: As I said, when they first took authority and we established the targets, the targets were very individual for each LHIN. We have a provincial target on many of the indicators, but each LHIN would have been, in varying degrees, closer or further away from that provincial target. We would have established individual LHIN targets for them. If a LHIN was considerably higher on one, we may not have set the provincial target for that LHIN to hit initially. We have continued to set targets, every agreement, year over year, to try to achieve better performance.

We meet quarterly with all of the LHINs around their performance, and we have discussions with each LHIN around their individual performance: what they're doing; the challenges that they're having; and where we, the ministry, can support them, if there is something that the ministry can do. It's just to understand what their particu-

lar issues are. There are obviously, as I say, varying issues across the different LHINs, so we have those quarterly discussions and try to move performance with the LHINs. We do monitor quarterly; they do submit their quarterly reports to us. Then the following year, when we come to their performance agreement, again we would look at where they've come and have that discussion once again around performance, where we want them to go and how to move that target.

It's a very evolutionary, iterative kind of conversation and process.

Mrs. Jane McKenna: Let's say they don't meet the targets that you have. Where I find it confusing is, if they're all supposed to be at one level, first of all, how do you know, then, to micromanage and to know what targets each one is doing? That's confusing to me. If everybody's supposed to be at this level, and you've gone in and micromanaged because this one wasn't doing as well as this one, and now you're setting the targets for this one because it's not doing as well—my point is that they should all be at the same level. We shouldn't be giving compensation because one is different than the other.

I guess my question is, if their targets are not met, and you've gone and talked to them again, what happens then?

Ms. Kathryn McCulloch: As I said, it's an iterative process. The targets are—not aspirational. The targets are to be worked upon, to achieve those targets. If a provincial target is 182 days in 2006, when the LHINs assumed their authority—in 2007, they assumed their funding authority—some LHINs would have been considerably further away from that target. They may have been at 250 days—

Mrs. Jane McKenna: Why?

Ms. Kathryn McCulloch: Because that is where the performance was provincially at that time, for a number of factors: availability of surgeons, demand—I mean, there's a whole variety of factors that may come into play in terms of why a LHIN's performance would have been higher at the time. That was the purpose of setting targets.

I think we have moved from 2006, when those provincial targets were first established, and continue to work with the LHINs. It's not a matter of hit-or-miss; it's how do we continue to allow them and support them in moving towards achieving the target that we want provincially across all LHINs.

Mrs. Jane McKenna: Okay, so correct me if I'm wrong: We're seven years into this now. We're still having the same issues of still massaging people in a position where they've been for seven years? I would love to have this with me, if seven years later, as the MPP for Burlington, I'm still having targets that I should have been meeting back on day one.

How long are you going to—I guess where I'm confused is, it's seven years. When is the cap of when enough is enough? When are they all going to be at the same peak? That's a heck of a long time to give somebody to get up to snuff.

Ms. Kathryn McCulloch: I really don't know if that's a long time or not. I think it really depends on the issues and the factors that they are dealing with. If it's an issue of finding appropriate surgeons to perform—so wait-time surgery. There are lots of issues that the LHINs per se do not have complete control over in terms of those targets, and that's where the ministry also plays a role in supporting them: What kinds of policies and what kinds of actions do we have to take provincially to be able to also help move that marker as well?

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Mrs. Jane McKenna: So after all this time, seven years of doing that, you haven't been able to solidify that?

Ms. Kathryn McCulloch: I think we've made progress. If you look at the provincial picture, we have made progress on all of the indicators.

Mrs. Jane McKenna: So we're able to see all of this information, right?

Ms. Kathryn McCulloch: Yes.

Mrs. Jane McKenna: From each LHIN to the next, what their targets are, what the expectations are and where they've gone in seven years? From year to year, we're able to see that?

Ms. Kathryn McCulloch: Yes.

Mrs. Jane McKenna: Okay. And, for example, if you come back after a year and you say, "Okay, here we are with this LHIN. This is where we're at. We're basically at the same place we were," who actually rewrites the targets for them and gives them a goal to get to the next level? I guess that's my question.

Ms. Kathryn McCulloch: It's a process whereby a group of individuals across the ministry would meet with the LHINs—CEOs and chairs. There's a joint committee that meets to talk about the indicators generally, and then we have individual discussions with each LHIN's CEO and their senior staff, as well as ministry senior staff, around the targets.

Mrs. Jane McKenna: So is it the same people always setting the targets?

Ms. Kathryn McCulloch: It's the same positions—CEOs and senior directors from the LHINs—and generally within the ministry it's the same groups. From my branch, which is the LHIN liaison branch—we have the direct relationship—it's my ADM, as well as people from branches that have worked on wait times, which is a provincial strategy. There are a number of individuals across the ministry who would meet and discuss the targets with the LHINs.

Mrs. Jane McKenna: So I guess that if you're having the same people do the same targets and the same questioning for each LHIN and which ones are more micromanaged than the others, wouldn't somebody say at some point that the definition of insanity is doing the same thing over and over again? At what point do we bring someone else in here, to shake this up and get this to where we need to go?

Ms. Kathryn McCulloch: I don't know if the conversation around target-setting is where you can actually get

the improvement. You can set a more difficult target; that doesn't get you to the improvement. We meet with them to try and identify where the challenges are and where the opportunities are.

Mrs. Jane McKenna: So how do you get to that improvement, then? If after seven years you've been looking at what specifically can get them to the next place, what are the improvements that they need? It just seems so complex. We're making this more difficult than it actually is.

Ms. Kathryn McCulloch: I think it is complex. Each individual indicator may have a series of reasons or factors behind that particular performance. Provincially, we've done well. Each LHIN will have areas where they have done well and their performance has improved, and they may have areas where they continue to be challenged. It varies across LHINs. You're right; it is complex, and I don't think it is just setting a target. There is more behind it: to understand the reasons why the targets may or may not be achieved in a particular area in a particular period and what other factors are contributing.

Mrs. Jane McKenna: Okay. So, for me, I'd really like to see exactly what those challenges are for myself, so I'm going to look at that.

My next question is: How many LHINs have had to revise targets, and how many times have they had to be revised?

Ms. Kathryn McCulloch: We visit the targets on a yearly basis. Each year we are looking at trying to move the performance marker. We have provincial targets, and once we hit the provincial targets—I think that's agreed—the provincial targets have been set—

Mrs. Jane McKenna: But how many?

Ms. Kathryn McCulloch: How many?

Mrs. Jane McKenna: How many have actually had to have been revised? How many LHINs have had to have their targets revised?

Ms. Kathryn McCulloch: We revise the individual LHIN targets on a yearly basis. The provincial targets have not been revised.

Mrs. Jane McKenna: So how many have actually met the targets?

Ms. Kathryn McCulloch: It really is individual. I'll go through some of them. Central LHIN was at or below or within 10% of the LHIN target on all 15 of their indicators—there are 15 current indicators. Central East was at or below their LHIN performance targets for 10 of their 14 indicators. For 12 of 15 indicators, the majority of LHINs were at or below or within 10% of LHIN targets. So it varies, and it varies by target. For the 12 of 15 indicators that they were at or below, the ones that have particular issues are around knee replacements, and that's often an issue around surgeon availability, and repeat unscheduled emergency visits. However, we have continued to see the LHINs perform year over year or improve year over year.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. That concludes the time.

Ms. Gélinas.

M^{me} France Gélinas: Just a few questions on the presentation that you did. The first one is on the slide on page 6.

Good afternoon, Deputy.

Mr. Saäd Rafi: Good afternoon.

M^{me} France Gélinas: It has to do with the last bullet, that physicians, podiatrists, dentists and optometrists are not considered service providers. Was this a policy decision or is there a reason within the laws that exist that those were excluded?

Mrs. Jane McKenna: Point of order, Chair.

Interjection.

M^{me} France Gélinas: He will turn it on for you eventually.

The Chair (Mr. Ernie Hardeman): It's getting rather confusing. If someone was just watching it on camera and not hearing what was happening here, all of a sudden we have four people presenting instead of two.

Mr. Saäd Rafi: My apologies, Chair.

The Chair (Mr. Ernie Hardeman): If we could clarify—

Mr. Saäd Rafi: Saäd Rafi, Deputy Minister of Health and Long-Term Care. I noted that we were into a set of questions, so I was hoping that the committee wouldn't mind us coming to the table.

The Chair (Mr. Ernie Hardeman): I would just point out that our program this afternoon was set up that for the first hour we would hear from the legal branch. We had the presentation, and we're now having the questions. We then will be hearing from the ministry.

Mr. Saäd Rafi: Sure. We'll take our leave.

The Chair (Mr. Ernie Hardeman): Thank you. It was getting a little confusing—

M^{me} France Gélinas: We'll see you soon.

The Chair (Mr. Ernie Hardeman): —as we were shuffling around our presenters.

With that, we'll go back to your questions, Ms. Gélinas.

M^{me} France Gélinas: Did you hear my question?

Mr. Robert Maisey: I did hear the question. Just for the transcript, I guess, I'll repeat it. It was around subsection 2(3) and the list including podiatrists and physicians, and whether it was a policy choice or whether there was a legal reason. The answer is that it was a policy choice.

M^{me} France Gélinas: So there are no legal reasons that would prevent family health teams or individual fee-for-service physicians to be governed under the LHINs if the ministry so chose?

Mr. Robert Maisey: That's right, except this provision would have to be changed, and I'm sure there would be other provisions in the Health Insurance Act that would also have to be changed. But by statute, the Legislative Assembly could change this provision so that physicians were funded and held accountable through LHINs, yes.

M^{me} France Gélinas: Okay. My next question is on your slide deck page 9. In there, the last bullet point, you say that the minister shall "Seek advice from mandated

province-wide planning organizations”—you give the example of Cancer Care Ontario—“in developing the provincial plan” that they have to put out. Is the balance of how much comes from the ministry and how much comes from the planning organizations defined or is it really depending on how things go?

Mr. Robert Maisey: It's not defined. That provision simply requires the minister to seek advice from those organizations.

M^{me} France G  linas: Okay. I'm on page 13. My first series of questions will just be cleanup little questions.

Part IV, funding and accountability, the last bullet point again: “LHINs can share information they receive from health service providers with each other, the minister and the Ontario Health Quality Council.”

“Can share” is different from “must share.” Is there any place in regulations or otherwise where it's stated what must be shared with them and what information the LHINs could choose to not share, if they see fit?

Mr. Robert Maisey: There isn't. The purpose of this section is to facilitate the sharing of information as needed; for example, where a health service provider, such as a significant hospital, provides services to residents in one or more LHINs, to allow those LHINs to share information back and forth between one another. So it's permissive rather than mandatory.

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M^{me} France G  linas: So if the LHINs get patient-specific information, with this part of the bill, are they allowed to share patient-specific information with each other, with the minister and the Ontario Health Quality Council?

Mr. Robert Maisey: The LHINs should not be receiving patient-specific information unless the patient has consented to it. Section 22—

M^{me} France G  linas: But it is for a patient who has consented to share; usually it has to do with complaints that they share that information with the LHIN. Then does that automatically mean that that personal information that the patient has willingly shared the LHIN becomes available to other LHINs, the minister and the Ontario Health Quality Council if that LHIN decides to share?

Mr. Robert Maisey: I don't think it would be under this section, because this section deals with information that's not personal health information. I think the way that that would be shared is either under the Freedom of Information and Protection of Privacy Act or under the Personal Health Information Protection Act. It wouldn't be this section, because this section doesn't authorize the LHIN to collect the personal health information.

M^{me} France G  linas: All right. So, in my little brain, what you just said, does that mean that the personal health information supersedes the fact that the LHINs can share information, that if it is personal information that they have, they would not be allowed to share it, although we have written in section 22 of the bill the exact opposite?

Mr. Robert Maisey: This section deals with non-personal health information.

M^{me} France G  linas: How do I know that?

Mr. Robert Maisey: Because section 22 speaks about, “A local health integration network may require ... any health service provider to which the network provides funding” to provide information to the network “other than personal health information.”

M^{me} France G  linas: And you're reading from?

Mr. Robert Maisey: Subsection 22(1).

M^{me} France G  linas: You're reading from the bill, from the act?

Mr. Robert Maisey: From the act, yes. That's subsection 22(1). Your question is about subsection 22(4), and that section talks about, “A local health integration network may disclose information that it collects under this section.” So “under this section” means section 22, and section 22 provides that a LHIN can collect information “other than personal health information.”

M^{me} France G  linas: Okay. That makes sense.

My question then has to do with, and I lost the page that this was on, where you talk about how the ministry—let me find it again. The ministry can issue orders. They can—

Mr. Robert Maisey: That would be section 28, is it, on page 16?

M^{me} France G  linas: Yes, exactly. Thank you. The second bullet point: “The minister, on the advice of a LHIN, can require a health service provider to cease operating, amalgamate with another health service provider, or transfer its operations to another entity.” Why couldn't the LHIN do that on its own? Why the minister?

Mr. Robert Maisey: That goes to one of the significant policy decisions that was made when this LHIN legislation was introduced, which was to separate integration of services from the integration of corporations or the integration of health service providers.

Section—no, let me speak to the policy intent without referencing the sections for a second. The policy intent was that LHINs would be able to integrate services; the minister would be able to cause amalgamations of corporations, of health service providers. So there were restrictions placed on LHIN integration, that they could only move services around without the consent of a health service provider; they were not able to, for example, require hospital corporations to amalgamate. That provision for hospital amalgamations, for example—I pick them only because that has happened—was left to the minister under section 28 in circumstances where the hospitals were not willing or were not consenting to that amalgamation.

M^{me} France G  linas: Okay. Thank you.

Ms. Cindy Forster: Do we have some time left?

The Chair (Mr. Ernie Hardeman): Ms. Forster.

Ms. Cindy Forster: I have a couple of questions. At the very beginning of the document today, it talks about the principles of the health care system, including references from the Canada Health Act—promoting the

delivery of health services by non-profit organizations and achieving an integrated health system.

How are we doing with continuing to deliver services in a non-profit as opposed to for-profit way? Because it seems to me that many of the agencies that open in the province are non-profit. For example, new long-term-care beds are still being awarded to for-profit agencies over non-profit agencies. So we have this kind of guiding principle, but it seems not to be in keeping with what we're actually doing.

Mr. Robert Maisey: Well, I can speak to the technical aspects—the principle stated, as you said, in the preamble—I can't really comment, as legal counsel, on the policy choices that have been made. There are a number of other provisions in the statute that place restrictions on the ability of integration to occur when there's a transfer of service, for example, from the not-for-profit sector to the for-profit sector. That's generally not permitted without the consent of the organizations involved.

Ms. Cindy Forster: With respect to pages 15 and 16 of the document, around the integration and devolution piece, it says the LHINs "cannot require the transfer of charitable property to a provider that is not a charity." Can that voluntarily happen?

Mr. Robert Maisey: Technically, yes it could happen voluntarily. However, there would be consequences for both organizations, not under this statute but under other statutes. When you transfer charitable property from a charity to a non-charity, there are significant tax consequences for that, and there are also consequences under the Charities Accounting Act that would come into play. So, technically it would be possible, but there would be significant consequences for that.

Ms. Cindy Forster: There was some reference, as well, to municipal restrictions under section 28. Can you explain that a little more—municipal governments and long-term-care homes?

Mr. Robert Maisey: Right. I'll give you the specific section. It's subsection (3) of section 28, so 28(3).

As I was mentioning in response to a previous question, the minister is allowed to issue orders around corporate governance to amalgamate health service providers. Some health service providers, as you know, are municipal governments that operate long-term-care homes. These restrictions prevent the Minister of Health from causing the amalgamation of municipal governments, because clearly that's something that should occur under the Municipal Act. So that provision speaks here to the fact that the Minister of Health is not permitted to require municipalities to merge just because they provide a health service. Also, the minister is not permitted to close down a municipal home. That's the purpose of those provisions.

The Chair (Mr. Ernie Hardeman): One more question.

Ms. Cindy Forster: Okay. Just further to that, the minister cannot order a not-for-profit health service provider—for example, a hospital that has long-term-care

beds—to transfer assets to a for-profit health service provider. However, can the non-profit voluntarily do that, and what are the implications?

Mr. Robert Maisey: That goes to the question you asked previously, which is that a not-for-profit doing that would be hit with tax consequences for that. If that's a transfer of service, then the LHIN would have to be given notice of that under section 27. So the LHIN would also be able to say yes or no to such a transfer.

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The Chair (Mr. Ernie Hardeman): Thank you. That concludes your time. The government: Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair. I will start with slide 6, and most of my questions will be fairly technical.

You talk about health service providers and you also, of course, mention public and private hospitals. That would include the federally incorporated hospitals as well, would it? There are a few in Ontario.

Mr. Robert Maisey: Yes. Hospitals that are incorporated under the federal corporations act—

Ms. Helena Jaczek: Would also be included.

Mr. Robert Maisey: Right.

Ms. Helena Jaczek: Thank you. "Community service providers," on the same page: That strikes me as a rather broad term. How do you define community service providers? Are these services where the Ministry of Health and Long-Term Care provides funds to these agencies?

Mr. Robert Maisey: Yes, that's right, and it's defined in the definition as "a person or entity approved under the Home Care and Community Services Act." I'm afraid that in this slide deck I was trying to use fewer words than more. It would be an organization that is a community service provider or a community agency under the home care legislation.

Ms. Helena Jaczek: Okay. Thank you.

Mr. Robert Maisey: If I can just add to the previous question: You were asking about federally incorporated hospitals. Those would be federally incorporated hospitals that are public hospitals under the provincial Public Hospitals Act. I'm not sure if there are any other types of hospitals around, but there used to be hospitals that were federally incorporated and only funded by the federal government. Those would not be included under this legislation.

Ms. Helena Jaczek: I'm thinking of Collingwood. In a previous committee, we heard about that.

Mr. Robert Maisey: Right, and I was thinking of some of the hospitals that used to exist—and I know that they've been reorganized—in the Far North.

Ms. Helena Jaczek: Yes, so not those. Thank you.

Moving on to slide 7, the LHINs "are crown agencies": Are the 14 LHINs, with their boundaries, described in the act?

Mr. Robert Maisey: No. The boundaries are described in the definition of "geographic area" in section 2. What happened at the beginning when the LHINs were first created was that the boundaries were described and

set out on the ministry's website, and the statute makes reference to that. The boundaries are on the website.

Ms. Helena Jaczek: So if there was a desire to change boundaries, it would not require an amendment to the act?

Mr. Robert Maisey: That's correct.

Ms. Helena Jaczek: It would be a ministerial order or something of that nature.

Mr. Robert Maisey: It would be a regulation.

Ms. Helena Jaczek: A regulation. Okay, thank you.

On slide 8, LHIN "board meetings are open to the public," obviously with the exceptions of finance and personnel issues, etc: Are they required to advertise their meetings?

Mr. Robert Maisey: Yes. Subsection 9(3): "A LHIN shall give reasonable notice to the public of the meetings of its board of directors and its committees."

Ms. Helena Jaczek: And how are they required to do that? On their website?

Mr. Robert Maisey: That's right. The statute doesn't speak to the operationalization or how that's to be done, but my understanding is that typically, their website does have notice of the meetings.

Ms. Helena Jaczek: That's considered sufficient.

Mr. Robert Maisey: That's right. In fact, I would go further, now that you remind me. There's a provision on information to the public, which is section 36. Where a LHIN is required, under the statute, to make something public, then it's to do so on its website. That's section 36.

Ms. Helena Jaczek: If we could move on to slide 11, you make reference to a Health Professionals Advisory Committee, with members that are prescribed in regulation. Could you tell us who these people are?

Mr. Robert Maisey: Yes. I'm afraid that's a part of the presentation I didn't get to, which is on slide 25—

Ms. Helena Jaczek: Oh, okay.

Mr. Robert Maisey: —but that's fine. If we can take you to slide 25, there's a heading that talks about the Health Professionals Advisory Committee. In the second bullet, "The committee must be comprised of physicians, nurses, a dietitian, a pharmacist, an occupational therapist, a psychologist and three" other people, as decided by the LHIN. Then there are some rules in the regulation about who is not permitted to be on the committee.

Ms. Helena Jaczek: And who is not? This is, I guess, the next bullet.

Mr. Robert Maisey: Right.

Ms. Helena Jaczek: Members of a trade union?

Mr. Robert Maisey: No, it's not members of a trade union; it's board members. That would be the executive members. The intention with the Health Professionals Advisory Committee was for LHINs to receive advice on the local health system, among other things, from front-line health care workers. There is a series of people who are not permitted to be on this committee. That would include members of advocacy organizations and members of the executive of a trade union. However, people who are employed and are members of a trade union are permitted on this committee.

Ms. Helena Jaczek: And the size of this Health Professionals Advisory Committee?

Mr. Robert Maisey: The size is up to 15. That's in subsection 5 of the regulation, section 1.

Ms. Helena Jaczek: Okay. On slide 12, your second bullet: "Permits the minister to adjust a LHIN's funding to take into account a portion of any savings generated through efficiencies of the local health system." Maybe that's for Ms. McCulloch. Does this mean that funding could be removed the following year if an efficiency is found?

Mr. Robert Maisey: Actually, I'll take that one. That is directed at provisions in another statute, which is the Financial Administration Act. The Financial Administration Act largely provides that if there is funding left over by the ministry or other organizations to which that statute applies, that funding has to be returned to the Ministry of Finance. This provision enables the Ministry of Health to not do that for a LHIN, so that a LHIN can keep the benefit of efficiencies that it creates. But it is permissive, not mandatory.

Ms. Helena Jaczek: So, to Ms. McCulloch: How do you deal with those situations, when you do find funding efficiencies?

Ms. Kathryn McCulloch: That particular provision hasn't been implemented in the act to date.

Ms. Helena Jaczek: But you've observed efficiencies. Is it usually that there's another area that the funding gets put toward?

Ms. Kathryn McCulloch: There are efficiencies, but that particular provision has not been implemented, so we've never defined the various terms in that. There was some further work that needed to be done in order to actually operationalize that particular provision. Currently, we just deal with it—

Ms. Helena Jaczek: So it's sort of permissive, and it's there.

Ms. Kathryn McCulloch: Yes.

Ms. Helena Jaczek: Okay. You've talked quite a bit about the LHINs' powers and the minister's powers related to integration and devolution, but what are the requirements of the health service providers? As an example, if a health service provider decides to cease a particular service, are they required to inform the LHIN before they cease a service?

Mr. Robert Maisey: If the service is funded by a LHIN, then the service should be addressed in the accountability agreement between the LHIN and the service provider. That would, I would expect, require some kind of a discussion between the LHIN and the service provider as to an amendment to their service agreement.

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Section 24 does require each service provider, separately and in conjunction with one another, to identify opportunities for the integration of services.

To your specific example, if the ceasing of a service by one service provider is really in order to integrate it with another provider, then that would trigger section 27, which requires the health service provider to give formal

notice to the LHIN, and the LHIN has 60 days to object to that.

With your question, there are a couple of ways in which the scenario can unfold. The two ways that I'm aware of, that I've described, would require some kind of discussion with the LHIN, either towards an amendment of the service agreement that the provider has with the LHIN, or a formal notice under section 27.

Ms. Helena Jaczek: To what extent does the ministry look at the service accountability agreements that every LHIN is involved with? We know you have an agreement with the LHIN, and the LHIN has the service accountability agreement with the provider. Following up on my previous question, it sort of depends on the degree of detail that that service accountability agreement has within it. Who monitors the service accountability agreements?

Ms. Kathryn McCulloch: The LHINs monitor their own agreements with their providers. However, the ministry has been involved in the actual development of the standard accountability agreements that the LHINs enter into with their providers, so the various hospital—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time for this delegation.

This also provides me with the opportunity to say thank you and to apologize for my previous ruling, on account of I noticed that both of the presenters presently are going to be part of our next panel, too. We were just trying to start the next panel sooner.

With that, we invite the rest of the panel to come up. I would just inform the committee that, obviously, any further questions we have for the first part, which has been the legal part of the actual bill—it would be quite in order to continue asking in that same vein in this one.

We will now hear from the deputy minister and Catherine Brown, the assistant deputy minister, health system accountability and performance division, and of course, the present two who were before us.

With that, we will provide you with an opportunity first to make your presentation and then, when you've made your presentation, Deputy, we'll open it to questions. The questions will be just in 20-minute rotations, because it's not set for a time limit.

Having said that, we do hope that when we get to the end of our time, we will have someone be able to end on a fair basis, so I may have to make the last round a little different than the 20 minutes. But it will be 20-minute rotations, starting with the third party.

With that, Deputy, the floor is yours. Thank you very much for coming here. We will look forward to your presentation.

Mr. Saâd Rafi: Thank you, Chair, and thank you, committee. My apologies for the previous interruption.

Thank you very much for the opportunity to speak with you today about the Local Health System Integration Act, 2006, or LHSIA, which sets out the legal framework for the establishment and functioning of local health integration networks, or LHINs. The ministry welcomes the standing committee's review of LHSIA.

The province implemented this reorganized system only six years ago. The purpose of this review of the legislation is to take a closer look at how the system is working and to identify and consider areas for enhancement or improvement. This is an opportunity to retool in order to make the system more effective.

M^{me} France Gélinas: Sorry, Deputy. I was just wondering if you had copies of your presentation.

Mr. Saâd Rafi: We should.

The Chair (Mr. Ernie Hardeman): I haven't seen them.

Mr. Saâd Rafi: My apologies. We meant to distribute it prior to me speaking.

M^{me} France Gélinas: No problem. I think they're coming.

Mr. Saâd Rafi: Okay. I'll pause.

The Chair (Mr. Ernie Hardeman): Deputy, it's not that they will not be listening to you if they have the presentation, but it's a great opportunity to write down the questions as we're going through.

Mr. Saâd Rafi: Of course.

Interjections.

M^{me} France Gélinas: No, that's the legislation. No biggie. We can take notes.

Mr. Saâd Rafi: My apologies. That seems to be the only thing I'm doing.

The Chair (Mr. Ernie Hardeman): You can carry on, and when they arrive, they'll come up.

Mr. Saâd Rafi: Thank you.

I'll just pick up. The purpose of this review of the legislation is to take a closer look at how the system is working and to identify and consider areas for enhancement or improvement. This is an opportunity to retool in order to make the system more effective.

Let me now provide you with a description of Ontario's health care system that existed before LHSIA came into force on March 28, 2006. In 2004, when the ministry was directed to draft the legislation, the province had 154 hospitals, 581 long-term-care facilities, seven ministry regional offices, 16 district health councils, 42 community care access centres, five health intelligence units, 37 local boards of public health, 55 community health centres, five academic health science centres, and more than 350 mental health programs. All these entities had differing geographic areas, funding flows and overlapping accountabilities. In addition, there was a variety of different not-for-profit community agencies that also planned services on a geographic basis and operated without broader system planning guidance.

District health councils had no funding authority. Their role was to provide advice to the ministry. The ministry planned and administered health care across the province, taking into account the DHCs' advice, along with the information provided by regional offices with respect to local and regional needs.

Looking at the Canadian context, by 2004, nine other provinces had implemented regionalization. Regionalization of health care entailed more than the devolution and decentralization of services from provincial govern-

ments to regional authorities. It included consolidation of authority from local boards and agencies, and some centralization of services. Regionalization was the remedy proposed for the diagnosis of fragmentation and incoherence made by commissions across the country in the late 1980s.

In most provinces, authorities are corporate entities unique from pre-existing provider organizations, some created through enactment of specific legislation. The relationship between government and the governance of authorities varies, but most jurisdictions appoint at least some portion of authority boards. The scope of responsibilities varies but generally includes a resource allocation role. The scope of health sector devolvement varies but mostly includes hospitals linking to community-based and long-term care. Primary care and drugs have not been included.

Let me now turn to a few examples of regionalization in other provinces.

In 2001, British Columbia consolidated 52 regional agencies consisting of 11 regional health boards, 34 community health councils and seven community health service societies into five health authorities and one provincial health services authority that manages provincial programs and eight provincial services. A new First Nations Health Authority was announced in October 2013.

In 2004, Alberta reduced 17 regional health authorities, or RHAs, to nine, with cancer and mental health and addiction boards continuing. In 2008, Alberta dissolved its RHA system, creating in its place a super-board called Alberta Health Services, AHS, incorporating the nine previous RHAs, or regional health authorities. I would note that they are now into another round of potential changes to governance, if not the structure, of the Alberta health system.

In Quebec, 18 regional boards were transformed into 18 health and social service agencies in 2003.

I provide these examples to demonstrate that in Canada, regionalization has taken many different paths in different jurisdictions. There is no common definition of a health region, no uniform understanding of what services should be regionalized and no consensus on the nature of governance.

It should be noted that in an effort at continuous improvement, most provinces have modified their initial reforms, some more than once. It takes time to get it right, and they have been at it longer than we have in Ontario. The development of LHSIA needs to be viewed in that context as well as the context of the province's fiscal situation at the time.

During the previous two decades, health care costs had risen substantially. Between 2001 and 2005, health care spending rose by an average of 8.2% annually. By 2005-06, health care consumed nearly \$33 billion, or 46% of total program spending. Predicted costs continued to exceed predicted revenues, and spending was expected to continue to increase, due in part to the cost of new technologies, new pharmaceutical products and an aging population with a higher prevalence of chronic illnesses.

Increased spending on health services had not necessarily resulted in better population health outcomes: Cancer mortality and obesity rates were higher in Canada at that time than in most OECD countries.

The public continued to raise questions about the sustainability of the health care system. Demographic changes, including an older population and an aging health workforce, along with the fiscal challenges, pointed to the need to transform the system.

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The sustainability of the health care system was seen as dependent upon reducing the rate of growth in health care expenditure. At the same time, the government directed that costs be reduced through efficiency and elimination of redundancy rather than through reductions in service. A new model of system management was called for.

The model under which we now operate is led by local health integration networks, 14 geographically-based organizations that are responsible for planning, funding and integrating services at the local level, as you've heard. LHINs were founded on the principle that community-based care is best planned and coordinated within the local geographic community.

In developing the legislation, the ministry sought input from hundreds of people across the province, including patient advocacy and community groups, labour organizations, health care providers and health-related associations. Since 2006, when LHSIA was proclaimed, LHINs have had the responsibility to plan, fund and integrate local health services, including hospitals; community care access centres, or CCACs; community support services; long-term care, mental health and addictions services; and community health centres. The number of CCACs across the province was reduced from 42 to 14 to align with the new LHIN boundaries.

LHINs are responsible for allocating more than \$24 billion in health care funding. The total funding for LHIN operations is approximately \$90 million, which represents 0.4% of the total ministry funding they receive. In 2012, the provincial budget reduced the LHINs' administrative budget by 5%.

LHSIA contains the legislative elements of the LHINs' accountability as it relates to governance, including annual and financial reporting requirements; reporting relationships and oversight structures and mechanisms; planning, system integration and performance management frameworks; community engagement; accountability and compliance mechanisms; and approaches to funding and allocation.

Several regulations have also been developed under LHSIA to facilitate the implementation of the legislation. The relationship between the ministry and LHINs, including specific accountability structures, is governed by LHSIA, the ministry-LHIN performance agreement, an MOU, management board directives and other applicable government policies.

As you've heard from my colleagues, each LHIN is required to enter into an accountability agreement with

the ministry—the ministry-LHIN performance agreement, or MLPA, as we call it—which sets out the key funding and operational expectations of the LHINs and the ministry. The MLPA reflects the government's role in setting priorities for the province's health care system while acknowledging the LHINs' role in identifying local priorities, as established in their integrated health services plans. The agreement reflects that Ontario has a single system with 14 networks that facilitate the co-ordination of care delivery among the regions. The MLPA also articulates the ministry's performance expectations of the LHINs, as you've heard.

Finally, the agreement sets out the ministry's and the LHIN's understanding of their respective performance obligations and identifies the scope of decision-making responsibility of the LHIN and the ministry for specified programs and services.

The current MLPA includes 15 LHIN performance indicators and associated targets, as well as the funding that each LHIN receives. LHINs report quarterly to the ministry on the MLPA performance indicators, such as wait times and ALC rates, as well as the financial health of the sector and of the LHIN itself.

The ministry has an MOU with the LHINs that sets out the relationship between the ministry and the LHINs. LHSIA sets out the roles of a LHIN, which include helping to develop and implement the provincial strategic plan and provincial priorities and services; working with others to improve patient care and access to high-quality health services, as well as continuity of care; disseminating information on best practices; improving the efficiency of health service delivery and the sustainability of the health system; allocating and providing funding; setting performance standards with funded health service providers and ensuring that they are achieved; being accountable for the effective and efficient management of the LHIN's human, material and financial resources; and carrying out any other objects the minister specifies by regulation.

LHINs have an obligation to monitor local health system performance and report on health outcomes by entering into service accountability agreements with health service providers they fund to establish and ensure the achievement of performance standards. They can compel health service providers to provide plans, reports, financial statements and other information that the LHIN needs to carry out its duties.

A key provision of LHSIA is to require LHINs to develop IHSPs, or integrated health services plans, every three years. The current plans run from 2013 to 2016. Essentially, the IHSP is a road map which guides health system improvements over the following three years. It sets the vision and identifies the integration priorities and initiatives to be delivered within available health system resources.

The IHSP demonstrates a devolved and local approach to integrated planning by reflecting ministry priorities. For example, in the current IHSPs, the LHINs have identified activities that they will undertake over the next

three years to support better care for seniors, people with chronic conditions and mental health, among some of the priorities.

To better assess their needs, LHINs must engage on an ongoing basis with their community, which includes patients, health service providers and employees who may be impacted by planning decisions. They also consult across their community about the needs and priorities of the local health system to seek the input that reflects the needs of their diverse populations, including the francophone community and aboriginal and First Nations peoples.

Beyond planning, funding and integrating local health care services, LHINs are now playing a role in the province's community health links announced by the minister nearly a year ago. Health links are intended to address the complex health care needs of about 5% of Ontario patients who consume two thirds, or 66%, of the health care budget.

Health links are accountable to the LHINs. Their leadership, governance and degree of integration are flexible and based on local needs, and LHINs are identifying where complex patients are within their region for health links. LHINs are also partnering with the ministry in the implementation of community-based specialty clinics.

As part of its action plan for health care, the government wants to shift procedures that don't require hospital stays into non-profit community clinics because it's a more appropriate and efficient way to ensure that Ontarians get the right care, at the right time, in the right place.

Hospital outpatient clinics and independent health facilities have long been a part of the provincial health care system. The ministry is working with the LHINs to transfer routine cataract procedures from hospitals to non-profit clinics covered by OHIP.

A major element of reforming the way services are delivered is reforming how they are funded. Funding reform started in 2012-13 and will be phased in over four years. We're now in the second year of health system funding reform.

Ontario is shifting the focus of its health care system away from one that has primarily been provider-focused to one that revolves around the person and the patient. The ministry is working hand in hand with health care experts, senior leaders, front-line providers and the LHINs to move from global funding towards a more transparent, evidenced-based model, where funding is tied more directly to the quality of care that is needed and will be provided.

Treating patients with the right care at the right time and in the right place will improve the health of the people of Ontario, which will reduce costs and preserve our health care system for generations to come. Funding reform is a key component to delivering better quality care and maintaining the sustainability of Ontario's universal public health care system.

An evidence-based system organized around the health care needs of a community will result in greater

access to care, better quality and value for their tax dollars by:

- funding hospital, long-term-care and community care providers based on how many patients they look after, the services they deliver and the specific needs of the population they serve;

- using the best available evidence and proven best practices to provide care that works best for the patient and for the system;

- incenting efficient and high-quality service delivery.

In the past, health service providers could choose to implement service changes in order to balance their budget. Now the ministry is moving to a system where funding is tied more directly to the care being provided to ensure that the people of Ontario get the health care that they need. The changes that are taking place have been informed by world-class providers, system leaders and stakeholders who treat the people of Ontario every day. The ministry is working with the health sector as partners to create a health care system that puts people first.

The ministry has many strategies in place to help providers make the transition to the new funding model. These will help to ensure that patient care is the top priority and health care spending is used to improve quality in a cost-effective manner.

Building on the work of our world-class health care providers and researchers, funding reform will give Ontario's leading providers the tools and a forum to establish best practices based on the best available evidence and world-leading innovations.

The people of Ontario will now receive care that is more focused on the entire patient journey. This shift in focus will encourage better value for money in the health system by spreading best practice, improving quality and lowering costs.

The government has made a conscious decision to focus on care in the community so that there are more options available to help older people stay at home longer. Care in the community is more affordable than care in hospitals or long-term-care homes, and home is where people typically want to be for as long as possible.

LHINs are closely involved in funding reform, given that it affects health service providers like hospitals and CCACs that fall under their jurisdiction.

Let me close by saying that now that the province is engaged in health system transformation, this is an opportune time in the evolution of the province's health care system to revisit LHSIA and see where we can strengthen and improve it.

We look forward to the feedback the committee provides us on how to strengthen the role of LHINs so that they can continue to drive transformation across our health care system, thereby ensuring it will remain sustainable for the future.

Thank you, and we'd be now pleased to answer your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

We'll start the 20 minutes, but with the indulgence of the committee, I have a question from the Chair. It's a

simple one. I was just wondering, from the legal branch, in your presentation, you pointed out that the LHINs must meet in public other than for finance, personnel, legal advice. In the presentation of what the LHINs are supposed to do, I have concern that it would be very difficult to find anything that didn't somehow touch legal, finance and personnel issues because of their responsibility, and when their structure is to pay out money, decide who gets it and how much they get, and personalities and fighting about that. In the end, how is there anything—I wondered if we could get a written response for the committee as to defining what part of their business would be in public and what part wouldn't?

1530

I know that the committee, in the period that's coming, is going to find a lot of discussion about whether in fact they are as open to the public as necessary. So I wondered if we could get, from the legal branch, a written interpretation of that section of your report.

Mr. Robert Maisey: Certainly, but perhaps I could try to answer the question now. Would that be all right?

The Chair (Mr. Ernie Hardeman): That would be fine with me. I don't have the right to ask questions now—just to ask for reports back.

Mr. Robert Maisey: What would you—

The Chair (Mr. Ernie Hardeman): If you could answer now, that would be super.

Mr. Robert Maisey: Let me give a try. The challenge with writing a PowerPoint presentation is that one crushes together a whole series of words. It may have given the suggestion that the exceptions were broader than they are. In subsection 9(5), for example, "personnel matters"—it's not just any personnel matter; it's a personnel matter that involves an identifiable individual. General, non-identifiable individuals: That wouldn't be in camera; that wouldn't be in private.

The legal matters would be litigation or labour relations negotiations or solicitor-client information. Financial, personnel or other matters: That subsection relates to things that would be disclosed that are of such a nature that the desirability of avoiding public disclosure of them in the interests of the person affected or in the public interest outweighs the desirability of having the meetings held in public. So there's a fairly significant restriction there around the information being in the interests of the person affected.

I don't know if that helps or not, but I do believe that financial information is frequently discussed in public by LHINs.

The Chair (Mr. Ernie Hardeman): Okay. Thank you. Yes, Deputy?

Mr. Saād Rafi: Just before questions, I was remiss in not introducing my colleague—second from my left—Catherine Brown, who's the assistant deputy minister who has responsibility for the work with the LHINs.

The Chair (Mr. Ernie Hardeman): Okay. Thank you. With that, we will start the rotation with the third party. Ms. Gélinas, we'll start your 20 minutes.

M^{me} France Gélinas: I still have two little loose ends before I get into the questions for the deputy. The first one is that—just refresh my memory. Because they are a crown agency, that means they're under the Ombudsman. Am I right?

Mr. Robert Maisey: That's right.

M^{me} France Gélinas: They are. Okay. And the second is—actually MPP Jaczek asked a question and it became more blurry than clear to me. On page 12, "Funding and Accountability:" Under section 17, "permits the minister to adjust a LHIN's funding to take into account a portion of any savings generated through efficiencies in the local health system." I take it that the regulations for that part of the bill have not been done.

Mr. Robert Maisey: I'm sorry that my answer made it more confusing. There are no regulations for this provision. It's simply a permission for the minister to not take back money when efficiencies are created. Instead of having a requirement at the end of the year that unspent monies come back to the Consolidated Revenue Fund, it's a permission for the minister to leave some of the funding with the LHIN where the LHIN has unspent funding because of efficiencies.

M^{me} France Gélinas: All right. At the end of the fiscal year, if the LHIN's budget is not fully spent, they write a cheque to treasury just like everybody else?

Mr. Robert Maisey: That's right; it comes back. They don't even write a cheque.

M^{me} France Gélinas: They just—

Mr. Robert Maisey: It comes back. That's right.

M^{me} France Gélinas: Okay. It comes back. But if this clause was ever acted upon—and I think, Kathryn, you told us—sorry; I should call you Ms. McCulloch. You told us that it was never enacted, as in, they were never allowed to keep any?

Ms. Kathryn McCulloch: We don't allow them to keep it, but the particular provision was never operationalized, so what percentage was never determined. We just haven't operationalized that particular provision.

M^{me} France Gélinas: I don't know what "operationalizing" means.

Ms. Kathryn McCulloch: If you look at the words, it's a per cent of that. Well, we've never determined what percentage we would allow and—

Interjection: The criteria.

Ms. Kathryn McCulloch: Exactly—the criteria that we would actually implement that and allow the LHINs to be able to keep that money.

M^{me} France Gélinas: So right now, if there's any money unspent, it gets taken back, just like everybody else. If we were to work on this, then there's a clause that allows for some money to stay year over year or from one fiscal year to the next, but you've never used it.

Ms. Kathryn McCulloch: It's efficiencies too. It's not just underspending. It's not just, "We didn't spend our money," so you get to keep it next year. It's that you found some savings through something that you implemented. So there are a few pieces that criteria would need to be established about what—

M^{me} France Gélinas: Okay. Deputy, you talked about engagement with the First Nations and engagement with francophones through the entity process, and you spent quite a bit of time explaining how the LHINs set their priorities. I wanted to better understand: How does the priority that those entities, whether it would be First Nations, aboriginal or francophone, how do those two—what happens when they don't line up?

Mr. Saâd Rafi: Well, the idea is for them to line up. There is an advisory council, as you know, for those entities. They are really just reaching a midpoint in their mandate, and they would use the same guides that we would talk with the LHIN about, in terms of the forward-looking document—the IHSP—the relationship they have in terms of accountability agreements, as well as their own assessment of the needs within those six entities.

If there is a challenge to that, then there is a dispute resolution process that LHINs have within their accountability agreements, for example, that I believe would also exist, in that there's a process of discussion, of joint resolution and then escalation through there. I would imagine that that could ultimately lead to a removal of funds. We have not seen a circumstance where that has arisen, I do not believe.

M^{me} France Gélinas: All right. I'm not familiar with the resolution process that you're talking about, so I'll give you a real life example. The francophone entity identified the need for a new community health centre in a francophone community. It makes this as a recommendation to their LHIN as the number one priority for the francophone entity for that region—a francophone community health centre. The LHIN's response: "Community health centres are not a priority. Here's our list of priorities. CHCs are not on it. Thanks for your advice, but go away."

So there's a process—explain that to me again. And where do those regulations or whatever—how come I don't know about that?

Mr. Saâd Rafi: One, I would hope they weren't that dismissive, but just suffice to say that was shorthand for the response. I don't believe this is something that's captured in regulation as it is in the, sort of, cut and thrust of how one does planning. That specific example of a community health centre would be more than just operating funding, potentially. It may require capital funds. I would like to have hoped the LHIN didn't simply say, "It's not our priority; go away, we have other priorities," but rather that it may not have been a priority at that time within that catchment area, and/or they would also have to consult with us, because they're not making capital decisions independent of the ministry.

It's hard to image that there is a very short conversation about something that is prepared and produced by community organizations, be they the entities or be they the LHINs, that look at the needs. However, having said that, not all needs can be met and not all priorities always align. I think that's just a fact of practical implementation and financial resource availability etc.

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M^{me} France Gélinas: I'm aware of this. I'm more interested in what is in place to settle those differences. The example is not that far away—sure, it took longer than my 30-second explanation to get to it, but at the end of the day, the LHINs do not see expansion of primary care as one of their priorities, but the francophone entity does. The LHIN says, “You have to make recommendations that fall within our priorities.” The francophone entity is saying, “Well, your list of priorities is not what our community is telling us is their list of priorities.” So what exists when priorities don't line up? You went through a resolution process that is foreign to me and that I didn't follow.

Mr. Saād Rafi: Maybe I'll address the last part secondly. The entities are structured to provide advice on the needs of their catchment area and community, and it is just that; it's advice. Advice is not always taken—can't always be afforded. The LHINs actually don't control primary care.

I probably misspoke in terms of—I was identifying their accountability agreements as an example of, in those accountability agreements, mostly with health service providers as distinct from these entities—but with a health service provider, the LHIN would have a dispute resolution process within the accountability—

M^{me} France Gélinas: Yes, but they're not a service provider; they're an entity.

Mr. Saād Rafi: Right. I said I misspoke on that.

M^{me} France Gélinas: Oh, okay.

Mr. Saād Rafi: That was probably not the right example to provide.

M^{me} France Gélinas: Okay. So for an entity, whether it be aboriginal First Nations or francophone, there are no dispute resolution mechanisms? The LHINs always win; the entity always loses?

Mr. Saād Rafi: I guess if you want to characterize it that way; it's not necessarily a won-lost scenario that we would provide. But the entities are there to provide their advice. The LHINs are there to undertake planning and accountability within the means and resources that they have. So, ultimately, the LHINs have to make that decision, yes.

M^{me} France Gélinas: Any other comments as to how it gets settled or anything like this?

Mr. Saād Rafi: I'm not sure that I would characterize it as something that has a settlement. A settlement implies to me that there's a contractual obligation or a contractual relationship that says, “I tell you to do X spending on Y activity. You will spend it. If you don't agree with me, then we have a process to resolve our dispute.” As I said, I muddled the explanation by getting into the accountability agreements, but they are advice-providers. Someone has to decide whether that advice is something that can be afforded or implemented at that time. In this case, it would be the LHINs in concert with the ministry.

M^{me} France Gélinas: At the beginning, it was actually my colleagues from the PCs who talked a lot about

accountability and meeting—you talked to us about a set of 15 quality indicators. I don't think you called it “quality indicators,” but indicators—

Ms. Lisa M. Thompson: Performance indicators.

M^{me} France Gélinas: Performance indicators—thank you. I know they're available on their website. Not all of them are up to date, and they're not always that easy to follow. Could you provide us with a one-table summary as to what those 15 indicators are—

Mr. Saād Rafi: Sure.

M^{me} France Gélinas: —how the 14 LHINs are doing, as well as over time, if you have them over time, when were those indicators put into place, and when was the last time they were updated?

Mr. Saād Rafi: Yes, we can get you that, because I think, as Kathryn McCulloch was saying, some indicators have come on at different times. I didn't catch all of that conversation back and forth, but maybe one point would be to mention that when we say the performance in a LHIN is at or below—and maybe this is obvious—we mean it has met or exceeded. I think that “at or below” terminology may suggest “below” meaning subpar performance. If the objective is X number of days in order to get cataract surgery, and they're at it, then they're right at that number of days. If they're below it, then they're exceeding.

So again, not trying to be trite about it, but the nomenclature may not be the best that we're using. But we'll get you the chart against the 15 indicators and the 14 LHINs.

M^{me} France Gélinas: How long ago were the current 15 put into place? When was the last time you made a change?

Mr. Saād Rafi: We added, I think, four or five—maybe “adjusted,” perhaps, is a better term to say—in fiscal 2011-12. The most recent data that would be there, since we're annually assessing, would be, I think, 2012-13, because we're in the 2013-14 year.

M^{me} France Gélinas: Do you assess quarterly or yearly?

Ms. Kathryn McCulloch: We revise them yearly, or we talk to the LHINs about the targets against the indicators yearly. They submit their performance reports against that. The indicators, we look at on a yearly basis. We may, to the deputy's comment, change some of those indicators—add some—but the targets are also adjusted on a yearly basis.

M^{me} France Gélinas: Okay. Do you want to—

Ms. Cindy Forster: Sure. Thanks.

The Chair (Mr. Ernie Hardeman): Ms. Forster.

Ms. Cindy Forster: You talked about the total LHINs' operation having a \$90-million budget, representing 0.4% of the total ministry funding that they receive. That 0.4% is their administrative costs. Is that what you're talking about?

Mr. Saād Rafi: Yes. Sorry, I'm being perhaps a little overly technical about it. That 0.4%, or about \$90 million, represents the salary, wages, benefits, overhead

expenses and administrative costs for the employees of the LHINs.

Ms. Cindy Forster: How is the actual funding to the LHINs—what criteria are used to determine how that money is divided up amongst the various regions that the LHINs represent? Certainly, we find, in other ministries—community and social services, education—that some areas are underfunded and other areas are receiving substantially more funding. How does that all play out in the process of deciding who's getting what?

Mr. Saïd Rafi: I think it's a long answer, but one of the things that you would look at would be everything from the catchment area: the density; the referral patterns to a hospital; and the nature of cases dealt with in that geographic entity. In some cases, the LHINs may be helping to administer incentives for services that would be harder to provide in a certain community versus other communities. Yes, that does potentially create inequities—sometimes more money in a particular area than you would ideally have or be able to look at in a very detailed manner.

One of the reasons we started the funding reform: to take a look, starting with hospitals, which represent about \$17.3 billion of the over \$24 billion that the LHINs administer, and then moving to community care access centres and then long-term care, to be able to pay for patient volume and acuity and put a price on those types of services, and recognize that that can only be done, in our view, up to about—the government decided to only go forward with 70% of that total budget.

Over time—this will take four or five years, perhaps, to do all those three areas—long-term care, CCACs and hospitals—we'll have a better ability to transfer funds where funds are needed, based on patient volume. For example, if there's a particularly heavy draw on funds in a region that is seeing referrals of complex patients, then that facility—be it a CCAC, be it a hospital—should be funded for that, and not have money left in that other area where those funds maybe were assigned in the first place. With the increased acuity and demographics of Ontario's population, I think this is a move that needs to happen and needs to happen on the pace that it is, if not maybe faster, and will allow us to address the types of concerns.

I think everybody would rather have more money in their community than they currently have. I think that's a human-nature response, because we want to be able to provide all the services possible to all the people in a community. That's just exceedingly difficult to do, for all manner of reasons of supply and demand. So it's a work in progress.

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Part of the fundamental role of the LHINs is to do the planning for that. For example, before they create their accountability agreements, they do a bottom-up approach, especially with hospitals, by asking them what their volumes were last year and what their projected volumes are for the next fiscal year, and then they take an assessment of those volumes to determine what will be the funding elements to that hospital, what will be the

elements in the accountability agreement. They work with us in that regard on quite a regular basis to then build this budget from the bottom up, because we do zero-based budgeting, as you know.

Ms. Cindy Forster: Do the LHINs work with each other when there are those kinds of disparities?

Mr. Saïd Rafi: They do. Whether it's a new initiative, whether it's an initiative that is evolving or requires some mid-course correction, they would strike their own working group within and among the LHINs. They have a collaborative that looks at some of these issues, which is managed by the Toronto Central LHIN.

I and my management team meet with them every month for a full day, and we go over emerging and existing issues. And they have several working groups and working tables that allow them to not only work this way within their organization and their community, but across all LHINs.

That has taken some time to evolve, because their first priority was to understand their geographic catchment area and serve the planning and accountability needs of that geographic area. Now they're looking up and out as well.

M^{me} France Gélinas: In line with what she was just asking, has the ministry ever done some reallocations between LHINs since they were put in place? Could you give me an example?

Ms. Kathryn McCulloch: The LHINs have actually reached out to us at times. I think in the Waterloo-Wellington area, between the Waterloo-Wellington LHIN and the Mississauga-Halton LHIN, they transferred funding for some community service providers that the LHIN identified they were serving population that was greater in the Waterloo-Wellington LHIN, so they did transfer funds between themselves. There are those kinds of negotiations that go on.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes that time. We'll get back around to you.

Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Deputy, for your overview. I'm very pleased to see on the first page that you recognize that this is an opportunity to re-tool in order to make the system more effective. I think all of us here looked at this, and most of us were talking about regionalization of health care services for the last couple of decades. This was obviously Ontario's first crack at it, and as you've noted, there were a number of changes in other provinces as time went on. I welcome the fact that you're open in that regard.

Just picking up a little bit in terms of the administrative costs that were mentioned, I seem to recall that one of the motivators for creating LHINs was that there might be some administrative savings. As you mentioned, there were seven regional offices, there were district health councils, and so on. Did you at any time compare what has occurred with the creation of LHINs in relation to administrative costs?

Mr. Saïd Rafi: Sorry. Just to clarify: comparative with?

Ms. Helena Jaczek: The previous regime with all the regional offices and the district health councils compared to the current structure.

Mr. Saād Rafi: Well, I would say that the costs today are probably at par with what they were when the ministry had 42 CCACs, 16 or 18 DHCs and seven regional offices. Given the amount of spending and the increase in complexity, I haven't done a full cost-benefit analysis, but I would say that that's my understanding of it. We have not sat down to do the sort of full economic benefit. I think that's really what's at the root of your question.

Ms. Helena Jaczek: But proportionately, seven years later, you're saying on par in terms of costs?

Mr. Saād Rafi: Yes.

Ms. Helena Jaczek: So as a percentage of the total budget, it would be less?

Mr. Saād Rafi: Yes, indeed.

Ms. Helena Jaczek: I think that's important to recognize.

Obviously, we've heard that there are certain health service providers included under the authority of the LHINs. Why were those particular areas considered for inclusion to start off with?

Mr. Saād Rafi: I wasn't there at the time of drafting, so that's why I'm looking at Robert or Kathryn.

Mr. Robert Maisey: Okay, sure; I'll try to answer that. My microphone's on.

It was a policy choice that was made at the time, and other regional models across the country have typically included hospitals, long-term care and home care services and have excluded drugs and physicians.

Ms. Helena Jaczek: So it was based on other jurisdictions' experience that this was where to start?

Mr. Robert Maisey: I think that's fair, yes.

Ms. Helena Jaczek: Is there any thought in terms of increasing the scope of responsibilities in terms of other inclusions?

Mr. Saād Rafi: There's no current work under way.

Ms. Helena Jaczek: There's not? So it's a question of trying to maximize the integration between the current service providers?

Mr. Saād Rafi: Yes. I think that oftentimes, especially these days, one rushes to evaluate and assess. I think they need to continue to deliver on the remit that they have before adding additional elements. Where we have primary care as part of health links, individuals are relating to the LHINs, but we are in the process of examining changes to the legislative authority of the LHINs.

Ms. Helena Jaczek: With my background in public health, I feel sure there must be some opportunities for integration. Are those being explored on an informal basis, where the local committees and so on make suggestions?

Mr. Saād Rafi: Yes. I would say that collaboration, co-operation and working in partnership to deliver information on vaccines, public health issues and preparedness—Dr. King, the Chief Medical Officer of Health, also participates monthly with the LHIN execu-

tives, and beyond that when committee opportunities arise. There is a better connection with public health units than there was at the outset.

Interjection.

Mr. Saād Rafi: Robert has just corrected me on something that I neglected to mention: The government has proposed, through regulatory amendment, to add independent health facilities, that the LHINs would be able to fund independent health facilities. Those might be diagnostic imaging and the like, so I stand corrected.

Ms. Helena Jaczek: And would Robert be able to hazard a guess as to why that regulatory amendment has been proposed?

Mr. Robert Maisey: Yes. It has been proposed. I don't think it's been filed, and I can't comment on whether it will be filed, but the proposal has been made to add independent health facilities. It's in connection with the community-based specialty clinic initiative of the Ministry of Health to move low-risk hospital services from hospitals to community clinics.

Ms. Helena Jaczek: So, then, as I understand it, you have the current health service providers, you're monitoring through the accountability agreement in terms of these 15 indicators that we'll see, and you want to get everybody as up to speed as possible and then gradually, potentially with new initiatives, look at further integration? I know the ministry is involved in long-range planning and so on, so can you give us any idea about what might come down? Just any ideas that you may have?

Mr. Saād Rafi: They're undertaking integration activities at various levels within each LHIN, and varying amongst LHINs all the time. It isn't restricted to having to hit a certain milestone. We could talk about some examples that have taken place, but just down the street, we have a couple of examples where there's voluntary merger activity taking place—UHN with the Toronto Rehabilitation Institute. We've had some examples in the Sault Ste. Marie area, where the Sault-area hospital's regional district facility has provided other services. In the mental health field, we've seen integration for the purposes of greater efficiency amongst the myriad of mental health agencies that may exist. Integration activities will continue and have continued. There are some 250 examples across the 14 of them over the last several years.

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Ms. Helena Jaczek: So you would feel that the LHINs are working as they were intended to. Would you say that we're achieving success?

Mr. Saād Rafi: I think the performance of the LHINs has demonstrated that they're meeting, to a great extent, the requirements of them. The interaction with their health service providers has suggested that they have tried to move the yardstick in certain areas. I think what was discussed earlier in the legal aspect of your discussion was that they're not meeting all of their requirements for a myriad of different reasons. I think that's an aspect of continuous improvement that every system is grappling with across the country.

Ms. Helena Jaczek: How much longer do I have?

The Chair (Mr. Ernie Hardeman): You have 12 more minutes.

Ms. Helena Jaczek: Oh, good. Okay. I want to return to my issue around boundaries. I think most of us in this room know that we get a lot of constituents calling into our offices very often concerned about home care and community care access centre services, especially as they seem to vary—or at least to our constituents, they seem to vary—depending on which LHIN you live in. We've determined that LHIN boundaries were established under regulation, but CCACs have been established on a specific geographic area. Are those geographic boundaries of CCACs also established in the statute or by regulation?

Mr. Robert Maisey: I don't think they are in the statute. The LHIN boundaries, just for clarification, are referred to in the statute, but they're published on the website. They're not set out in a regulation. To change the boundaries, a regulation would need to be made.

My recollection is that CCACs are not set out in statute, but I may need to get back to you on that if I'm wrong.

Ms. Helena Jaczek: I would really like to know that, because certainly many of my constituents who are referred to hospitals in Toronto are having considerable difficulty accessing the CCAC services back in the Central LHIN. So that extra step of communication from a Toronto-based hospital in the Toronto Central LHIN with a patient returning home to Central LHIN has been an ongoing issue for certainly my constituency office. I'd like to have that, Chair—make sure we get the boundaries of CCACs.

Are there any unforeseen consequences from the perspective of the ministry in terms of the creation of LHINs? Is there anything that perhaps was specified in the legislation that has been found to be a barrier to moving forward in terms of transforming health care?

Mr. Saäd Rafi: I'm not offering a personal opinion, but I think it's difficult to enshrine something in legislation and accurately foresee what would be necessary even three or five years out. So if that's true—I'm sure that could be debated, too—then I'm sure there's always going to be areas of improvement to legislation that would allow any entity to do more and do better and provide better value.

I don't know of specific examples that I would point to and say, "Section X could have been written differently." That, to me, is less the point than: Are governments able to create and Legislatures able to pass legislation that will stand the test of time in what is now a rapidly changing environment due to technology and the impact of persistent chronic illness that perhaps we didn't foresee well enough in the time that it took to draft and establish these entities?

Ms. Helena Jaczek: I'm wondering, though—thank you for that—whether, in some of these quarterly meetings—Ms. McCulloch, you were referring to them with the LHINs—do you ever hear of any impediments in terms of the legislation? Fundamentally, we're looking at

the legislation here. Is there anything that's holding LHINs back, or do they come up with any suggestions at any times in terms of any additional responsibilities, or is there anything within the legislation that is holding them back from their intended goals?

Ms. Kathryn McCulloch: I don't think the legislation does. Obviously, there's a list of health service providers, which we discussed already. It's currently what it is. But I think the legislation was enabling legislation. It's not really prescriptive, as some pieces of legislation can be. It really is enabling. We've been able to work with the LHINs and work within our system. I'll go back to something that the deputy commented on around the primary care piece. The LHINs don't have authority for primary care, but we have, through health links, strengthened that relationship and strengthened that connection. So I think we've been able to actually—sorry for the use of the word; it's bureaucracy—operationalize the legislation, or, in enacting it, we have been able to work through any challenges that may have been identified. But we don't hear that from the LHINs on a quarterly basis, no.

Ms. Helena Jaczek: When you have a particular LHIN that has had great success in meeting their 15 indicators, how is that information shared about those best practices with the other LHINs?

Ms. Catherine Brown: As the deputy mentioned, we meet with the LHINs on a monthly basis, with the senior management team. They share with each other and with us some of those best practices and learnings. They also meet with each other and work very collaboratively on sharing that information. In the meetings that Kathryn McCulloch spoke of, the quarterly meetings that we have, where one will say, "We've had some success in this area by doing this," we indicate, "Did you know that this one was struggling with that same problem? Have you been in touch?" We put them in touch with each other if they haven't already been. They're very good at sharing their best practices across the 14, particularly where they have similar populations or similar problems.

Ms. Helena Jaczek: You made reference, Mr. Maisey, in terms of the minister's powers on the advice of a LHIN in terms of integration. Has the minister ever invoked that power?

Mr. Robert Maisey: That's a section 28 order. No, that power has not been used since this legislation was enacted. It was modelled on a provision that used to exist under the Public Hospitals Act and previous ministers had used, but not under this legislation.

Ms. Helena Jaczek: So when the deputy is talking about some of these examples, basically it's the parties coming together and voluntarily agreeing in terms of, "This makes sense for our community," and so on.

Mr. Saäd Rafi: They would have facilitated that.

Ms. Helena Jaczek: Yes. Could you maybe give us some more examples of those successes?

Mr. Saäd Rafi: Certainly. Erie-St. Clair: They've had some combination of, for example, integration. The Brain Injury Association of Chatham-Kent has gotten together with the Sarnia-Lambton Stroke Recovery Association

and they've created one corporate entity, which has really helped to provide better coordination for brain injury and stroke services in Sarnia-Lambton overall, plus reduce administrative costs through back office integration.

Huron-Perth in the southwest: Huron Perth Healthcare Alliance and the Alexandra Marine and General Hospital in Goderich are coming together to provide obstetric services in Huron county. For the last 18 months, they have had a site, the Clinton site. The Huron Perth Healthcare Alliance was unable to get enough physician coverage and staffing coverage for obstetrical services, so they've come together and they're sharing resources so that that part of the LHIN can get services that they were having a hard time filling.

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This is a bit of response to the—sometimes you're progressing well on certain performance requirements, and you may lose a key surgeon or you may lose a key leader, and that sets you back a little bit.

Again, South West has had some breast cancer co-ordination work between St. Joe's and London Health Sciences Centre, in London, whereby they've had a rapid-access breast cancer diagnostic and surgery centre, which was located at St. Joe's. They amalgamated some services there for improved screening for women with potential for or high-risk of breast cancer, and mammography screening services.

I can keep going, if you like.

St. Joe's Healthcare in Hamilton—this would be in the Hamilton Niagara Haldimand Brant LHIN—with Hamilton Health Sciences Corp.: It's a transfer of mental health and addiction services to St. Joe's, and then St. Joe's transferred their pediatric services to Hamilton.

Again, this is a coalescing of services so that greater volumes make for better outcomes, and that has been a theme throughout several of the voluntary or otherwise integrated services.

Again, acute stroke service integration in Hamilton Niagara, from Norfolk General to Brant Community Healthcare: another voluntary approach to acute stroke and patient rehab at Brant. This will help to give more equitable access to the stroke recovery model that has been established as a best practice, to improve patient outcomes.

West Lincoln Memorial and the Hamilton Health Sciences Corp. have just recently announced the intention to amalgamate, whereby the 52-bed community hospital at West Lincoln will come under the aegis of Hamilton Health Sciences centre, allowing it to leverage some of the clinical care aspects of an academic health sciences centre, and perhaps Hamilton Health Sciences to take advantage of the aspects that West Lincoln provides: a high understanding of geriatric services and a high understanding of acute geriatric needs.

Trillium Health and the Mississauga hospital have come together as Trillium Health Partners in the Mississauga Halton LHIN—I think about a year ago now; time has gone by quickly.

Sunnybrook, here in the Toronto Central LHIN—Sunnybrook, up on Bayview—has had a merger with St.

John's Rehab Hospital—again, a very natural patient flow for Sunnybrook, given that they have their veterans' centre and a lot of their patients go to—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

If I could just take a moment again, it relates to the questions that Ms. Jaczek asked. This hearing is somewhat different to what normal hearings would be when the ministry comes in to speak to us. I just wanted to read the committee's responsibility:

"Input regarding the extent to which LHINs have fulfilled their obligations under the act, including input from, but not limited to, LHIN board members and employees, board members and employees from other health service organizations and health care policy" professionals in the health care sector.

I just wanted to point out that generally, the ministry reports and supports everything that's in it, making sure and defending that it's being operated properly. I think the committee will be well served, if not today but at some point, if we actually hear from the ministry as to her question: If you were to rewrite the act, what would you put in that would make it work better, as far as the crown corporation delivering the services that they're delivering? I think it would be quite helpful for the committee.

I'm not saying this in any contradiction to what you've done. I just think it would be very helpful, as health professionals, to tell us where some improvements could be made.

I'll just leave that with you, and we'll go to the official opposition. Ms. Thompson.

Ms. Lisa M. Thompson: Thanks very much, Chair. Welcome to the committee. I appreciate your being here.

I want to go back to the IHSP 2013 to 2016, a road map for improvements. But before we do that, I have a question to ask of you, Deputy, and it's kind of picking up from where my colleague left off. You're going to provide in your report the targets that are being met and the 15 elements, and that's going to be very interesting and useful, but today, for the purposes of this committee, if you were to rate overall the LHINs in Ontario, their performance, from one to 10, where would you place them? One being—

Mr. Saäd Rafi: Are you asking my personal opinion? Because I really don't have any.

Ms. Lisa M. Thompson: No, from the ministry.

Mr. Saäd Rafi: I don't know how to answer that. I haven't thought about it.

Ms. Lisa M. Thompson: Okay. I'll go down the line; I'll ask each and every one.

Mr. Saäd Rafi: By all means.

Ms. Catherine Brown: I think, as Kathryn McCulloch described earlier, there are 15 indicators, and every LHIN varies from time to time. Sometimes there's a health service provider shortage; sometimes there's a merger going on; sometimes there's a change. I think overall their performance is in keeping with what we would anticipate in regard to how we've set the indi-

cators. I don't think there's any, on a scale of one to 10—you know, who's at one and who's at 14. They're all performing consistent with how we've set out the expectations for them to be performing. That being said, they're at varying places along the continuum owing to local circumstances.

Ms. Lisa M. Thompson: Okay. What areas do you feel need to be improved upon? What are you hoping to see in the IHSP 2013 to 2016 being submitted from your LHINs? You must have a sense of what areas can be improved upon.

Mr. Saād Rafi: Since the LHINs are not doing planning and accountability for the entire system, there would be areas—and we are looking at this when we look at our health system funding reform—of appropriateness. Let's say that you establish a target for cataract surgeries. One thing that research is telling us on vision care is that if you're exceeding that target—and it's not a bunch of bureaucrats establishing that target; it's done by clinicians in the community that feel that for that type of surgery the wait times could be at this level. So if you're exceeding that by a great deal, I think the first question one has to think about is, are we doing cataract surgeries too soon, too early, too often, and so appropriateness has to be part of that assessment and that determination.

So when we look at the IHSPs for the next three calendar or fiscal years, we want to make sure, as we move to a system of activity-based funding, this health system funding reform, that we're not only looking at, of course, safety, access, which is about hitting targets, but also appropriate access to targets. I'm not suggesting that means people should wait longer, but certain procedures may not be necessary in every circumstance. The LHINs' contribution to that is not solely their responsibility, because they would have to also work with individual hospitals and those surgeons to determine. In some cases in other jurisdictions, some surgeons are recommending—I'm just going to keep picking cataract—cataract surgery that may not be necessary or as soon as it's being recommended. So we need to work with those clinicians out in the community to provide guidelines and guides for that sort of thing. That's one area.

Ms. Lisa M. Thompson: All right. In terms of road maps for improvements, have you reviewed the PC Party white paper with regards to some of our suggestions for improving the delivery of health care on the front lines?

Mr. Saād Rafi: Briefly, yes.

Ms. Lisa M. Thompson: And what is your reaction to our concept of health hubs?

Mr. Saād Rafi: You see, I am continually resisting because you're asking questions that sound more like opinion, and as a public servant, I'm providing advice, not opinion—well, that's my job. And so I would say that there are elements in the white paper that, if you look at the hub notion, I would equate that to health links for many reasons that have to do with where services are being delivered, how they're being delivered, who is managing that care for patients and the cohort of patients.

I believe the white paper doesn't get into too much on the cohort, but it suggests that there is a need in what we would call sub-LHIN or sub-region activity.

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What we have not explored is the commissioning model that is also in the paper. That is more akin to the UK commissioning care groups led by primary care physicians. I don't have an opinion, but we just haven't examined that as a model.

But where we have health links, where there's primary care involvement—and by the way, 65% of primary care physicians must be part of a health link—one could suggest that that's getting to the types of notions that are in the white paper. That's how I would address your question.

Ms. Lisa M. Thompson: Okay. We'll leave it at that.

I also want to pick up on the line of questioning Ms. Forster was asking with regard to budgeting. It's interesting. I jotted down a few comments: Budgeting is based on demographics; supply and demand. I was getting a little nervous there because I represent a rural riding. We have hospital organizations that currently are being treated the same as one hospital under one roof. But the reality is, this one organization that has been incorporated technically has four hospitals under four separate roofs. They feel they're at a disadvantage because they're being treated as if their hospital is all aligned under one ceiling. There's just invariably expenses and operating costs that they're taking on the chin as a result. So I'm wondering if, going forward with the road map for improvements, there's going to be some consideration for these unique situations in rural Ontario. For goodness' sake, services should not be based on demographics, from my perspective.

Mr. Saād Rafi: Yes. A couple things—may I ask, which hospital?

Ms. Lisa M. Thompson: South Bruce Grey—no, Bruce South Grey.

Mr. Saād Rafi: I cannot remember off the top of my head if—when I said demographics, it was amongst a list of many things. We're not just looking solely at one dimension.

In the funding reform, for example, for hospitals, we have included, I think, 90 of the 154 hospitals, partly because some hospitals don't have the volume, the size, and have such a wide catchment area that it would be unfair to actually include them in a model that's a function of patient flow, price and so on. They do so many things in their community, to your point.

Ms. Lisa M. Thompson: The cookie-cutter approach right now is not working.

Mr. Saād Rafi: Our funding reform approach—you've characterized it as cookie cutter; I'll leave that. We're trying to be sensitive to northern and rural hospitals. In addition to that, we've provided a 1% increase in a zero-increase environment to northern and rural hospitals this fiscal year.

Ms. Lisa M. Thompson: For one year only, correct?

Mr. Saād Rafi: Well, we only do annual budgets. We don't give multi-year funding indications.

In addition to that, there's \$20 million available that those hospitals, along with their LHINs, have decided how they're going to provide and use. That money has been made on a more permanent basis, not just one-time funds, to your point.

Nothing's perfect, I would grant you, but we're not trying to simply say one size fits all.

Ms. Lisa M. Thompson: Okay. Ms. Jaczek was asking specifically about the provision of dollars to independent health care providers. I heard you share an example of imaging. That might qualify for dollars from LHINs. Would you also extend that same consideration to the likes of laboratories?

Mr. Saäd Rafi: It isn't contemplated under that regulatory change. That regulatory change I believe says "may"—that LHINs may fund independent health facilities, because I believe we're contemplating the community clinics to fall under the Independent Health Facilities Act. It's a regulatory amendment to the Independent Health Facilities Act, I believe. Robert?

Mr. Robert Maisey: That's right.

Mr. Saäd Rafi: Right now, we aren't contemplating community labs in that environment. We have a community lab program, with a model that is funded through the ministry's oversight.

Ms. Lisa M. Thompson: Thank you, Deputy. Jane?

The Chair (Mr. Ernie Hardeman): Ms. McKenna.

Mrs. Jane McKenna: Hi.

Mr. Saäd Rafi: Hello.

Mrs. Jane McKenna: Just a couple of things that I want to go through in my scribble that I have here. You had said that, ultimately, in the end, LHINs would—everyone would—like more money, but more money doesn't necessarily mean better service.

I think the first thing I want to ask you is on page 7. Ms. Forster was talking about your budgets, and you were saying that it takes four to five years for each LHIN to understand their catchment area. Is that from when you started back on—I know you're saying six years; I'm assuming it's seven years, March 28, 2013. I always thought it was seven.

Mr. Saäd Rafi: Yes.

Mrs. Jane McKenna: You said six, but we're pretty darn close to seven. Nevertheless, we won't—

Mr. Saäd Rafi: They started up in April of 2007, actually, in actual operation.

Mrs. Jane McKenna: Okay. So you're saying four to five years for them to understand their catchment area, for them to get all their information together? Is that back when you started, back in April 2007, then?

Mr. Saäd Rafi: Sorry; I'm trying to find the reference to "four to five years."

Mrs. Jane McKenna: You were talking with Ms. Forster about the monies that are allocated, right? The \$90 million.

Mr. Saäd Rafi: Yes.

Mrs. Jane McKenna: You were saying that it takes four to five years—

The Chair (Mr. Ernie Hardeman): The deputy is looking for the page that we're on.

Mrs. Jane McKenna: Oh, sorry. Okay—7.

Mr. Saäd Rafi: Of my remarks, I think you mean. Is that what you're referring to?

Mrs. Jane McKenna: Oh, sorry. Yes. It's your remarks.

Mr. Saäd Rafi: Oh, I know what the problem is. Mine are formatted for my eyesight. Anyhow, I'm sorry to interrupt you. Please, continue. I'll find it while you're talking.

Mrs. Jane McKenna: I guess my question is, is that four to five years when you started back in April 2007?

Mr. Saäd Rafi: Well, I think that's a very fine gradation for me to say, "Four years is up now. You should know everything about X." My only point there, I believe, was to suggest that we've seen in other jurisdictions that it takes time to make sure that you have a model that is working in the community. We have very, very vast geographies, as we all know. You all know better than I do, because you come from such varied constituencies. There are needs in constituencies that also change quite quickly, and I think that in health, that is probably as rapid as any sector or industry, and technology is a great example of that.

My reference to that, I believe, was to try to say that we need to ensure that we're not rushing to assess, but still need to make sure that we're keeping a strong pulse and push on delivery, but it does take time. I don't know if it's four to five years; I don't know if it's two years. In some cases, you might have had a community that's very organized. In our northern LHINs, I think they're a little bit more organized. They tend to work more harmoniously together out of some sense of, I dare say, necessity and perhaps not as many players in that marketplace. That would differ dramatically from Toronto Central.

Mrs. Jane McKenna: Yes. I was just picking up with what you said, and the only reason I'm saying that is because there has got to be somewhere where there can be, in stone, some type of answer, so that somebody can actually get to that goal to figure out what that is, right?

I guess, going back to that, how are we ever going to—I respect what the Chair is saying, along with Ms. Jaczek, about legislation, because it's very difficult. Hopefully we'll all have information we can bring forth to that, because if we're not able to get the LHINs to match their targets to get to where they need to go moving forward, how are we supposed to have the proper legislation written for that? I just find all of this very confusing, and I'm hoping that, in legislation, we'll be able to actually write it down moving forward to make it better, because clearly it's not.

My next question: Again, on page 7, you have that the administration budget was cut by 5% in the 2012 budget.

Mr. Saäd Rafi: Yes.

Mrs. Jane McKenna: Why? And how did you come up with 5%?

Mr. Saäd Rafi: That was a budget item for all agencies of government to demonstrate additional savings in the area of administration, set by the Minister of Finance. They, too, were required to deliver on that requirement.

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Mrs. Jane McKenna: You've said 5%; you've come up with that number. So the evidence-based of them being cut back 5%: How are they doing with that cutback of 5%?

Mr. Saād Rafi: I believe they met their obligation, because we would monitor their funding in that regard.

Mrs. Jane McKenna: So you would have evidence-based outcomes of that, that they're okay, they're doing fine—

Mr. Saād Rafi: Their administrative costs, yes. And we would see a reduction in that line item in their budget.

Mrs. Jane McKenna: Okay.

Mr. Saād Rafi: In each one of their budgets.

Mrs. Jane McKenna: So then my next question is, okay, clearly, Mr. Rafi—I'm not going to assume this; I'm going to ask you this. When they are setting the targets and trying to figure out, moving forward, how to make things better, are you part of that process?

Mr. Saād Rafi: Yes, ultimately we are. The ministry is. I am. The ADM is. The director in the LHIN liaison branch, and the minister's office—the whole process.

Mrs. Jane McKenna: Okay. Because you're there, you're the person who obviously is the hierarchy who's looking at all the aspects of it for the last six and whatever years, what—

Mr. Saād Rafi: Four for me.

Mrs. Jane McKenna: What improvements do you see that, just off the top—just anything that you could just say to me that's repetitive, that you see over and over again, that you would like to see fixed.

Mr. Saād Rafi: Well, I think that one can always do more on integrating services. Of course, you can only take that to a certain point, because then you get such an amalgam that it doesn't actually make a lot of sense. You can always integrate services. The committee motion talked about Drummond. He identifies back office as a good example, and the LHINs have examples of integrating back office services. More can be done. That would be the first thing that comes to mind.

Mrs. Jane McKenna: And so when you say more can be done, specifically do you have goals set for what that actually is, the more to be done?

Mr. Saād Rafi: That's what we examine—

Mrs. Jane McKenna: That's a big generalization.

Interjection.

Mr. Saād Rafi: Sorry.

Mrs. Jane McKenna: Yeah. I mean, "More to be done"—

Mr. Saād Rafi: It's all advice, by the way. It's not opinion. You may disagree, that I am offering my opinion. I would say to you quite steadfastly that this is based on what we happen to know in any inter-jurisdictional comparison we might do, and I think the assessments that we would make in working with them and reviewing their integrated health service plans, as an example, would be to determine, first, are you aligned with where government's going in the action plan? Second, if you are aligned with that, what actions and initiatives in that

IHSP demonstrate that you're aligned for person-centred care on the dimensions that are in the action plan? Then third is monitoring, again, not just the performance indicators, the 15—and by the way, in the main they're doing quite well against those—but also, what are you doing to then undertake the three components: plan, fund, integrate?

You had asked a question. On that third dimension, I feel that one can always do more and better in that area.

Mrs. Jane McKenna: Okay. So then my next thing is, you brought up about seniors, and I'll just say that for my constituency office we've had nothing but panic, alarm and seniors very upset about the physiotherapy and now with the cataracts. I guess with confusion where services have been cut, many feel they're falling through the cracks. I'm just curious. What was the LHINs' role in dealing with the impact of delisting and communication with patients to help them understand the new landscape of what's going on with the physiotherapy and the cataracts?

Ms. Catherine Brown: If I could comment on that, we worked very closely with the LHINs from the time of the announcement, and prior to that. They were aware that changes were coming. So we worked with the LHINs and with health service providers, both within the LHIN boundaries, some of the private physiotherapy clinics or the—sorry, not the private. The designated physiotherapy clinics are in a different area of the ministry. So we worked across the ministry and across the province with the 14 LHINs on day-to-day implementation.

There were a number of complexities in the middle of the summer right before the implementation date of August 1, where there were some judicial decisions that complicated the August 1 implementation date. We worked with the LHINs and the CCACs each and every day to make sure they were reaching out to patients, making sure every single person who was receiving physiotherapy was contacted, that they had an assessment through the CCAC for home care, regardless of where they lived or how they were receiving services.

We worked collectively with the LHINs to make sure that exercise and falls prevention classes were undertaken and were established across their regions. We worked first to replace existing classes that were under way and that were already existing in some way, shape or form, and then are looking to expand that across the LHINs' regions now.

Last but not least, we worked with the LHINs and each of their long-term-care homes to make sure they all understood what the change was, who their providers would be, how those would be funded and how they would implement that. The goal for the LHINs and the CCACs, as well as for us, was to make sure no one was left without care.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your time. To the third party: Ms. Gélinas.

M^{me} France Gélinas: Maybe I will continue along the same lines—maybe not.

I'm reading from the first deck that we got, that everybody knows the LHINs are there "to provide for an integrated health system to improve the health of Ontario for better access...." You should all know this by now; this is what the LHINs are there to do.

My first series of questions when I questioned the legal people was about primary care. Primary care is often the gatekeeper to access the rest of the health care system, but they're not funded by the LHINs. What was the rationale for that?

Mr. Robert Maisey: That was a policy choice that was made at the time. I think it's fair to say that no other jurisdiction in Canada has put primary care underneath their regional models.

M^{me} France Gélinas: Any more? As to, we don't do it because nobody has done it?

Ms. Kathryn McCulloch: I think that the other reality at the time—we're talking seven years ago—is that we didn't have as many group models as we have. We've rolled out 200 family health teams since then. There were a lot of individual practitioners, solo practitioners. I think there was concern around interfering with that relationship in that they bill fee-for-service, and LHINs tend to fund organizations or entities, not individuals. So I think we weren't in the same place then as we are even today around the types of group practices that we have in primary care. As the LHIN model evolved, so did our primary care model. We made advancements around some of that.

M^{me} France Gélinas: This exercise—I'm quoting your words—is to "look at how the system is working and to identify and consider areas for enhancement or improvement. This is an opportunity to retool in order to make the system more effective." Would you say that it's time to look at primary care?

Mr. Saäd Rafi: That's up to you. Again, I don't think any jurisdiction in Canada—I cannot speak for Quebec because I'm not as familiar—has decided to include that approach.

Kathryn McCulloch makes a really good point because it's really only Alberta, I believe, that has moved aggressively to group primary care physician models, and they're just now starting to do so. To add individual one-off GP relationships, I think, would be difficult from an oversight management point of view. But better integrating primary care—as you said, as the gatekeeper and sometimes as a referral partner to patients, especially complex—is really what's behind that health link model. We've tried to take a hybrid approach there, given that LHINs don't have legislative authority.

M^{me} France Gélinas: So if LHINs don't do primary care, why are community health centres funded by LHINs?

Ms. Kathryn McCulloch: Those physicians are employees of the health centre, so they're funding the health centre. The physicians are just employees under that model; they're not individual physicians who are billed on a sort of per capita basis.

M^{me} France Gélinas: Okay, then why not aboriginal health access centres or nurse practitioner-led clinics?

Mr. Saäd Rafi: Well, on the former I'm not sure. On the NPLC, the nurse practitioner-led clinic, it is the same: That came to light, after LHINs were established. It appears the decision of the government was to get that up as a group model that can be an augmentation to primary care physicians. Its oversight—it was decided to build it first.

Perhaps at some point, as you're suggesting, and maybe this committee might suggest, based on other people's input as well, who you will hear from, you may choose to bring that forward as a recommendation.

M^{me} France Gélinas: Has the fact that the community health centres have been under the LHINs brought us closer to better access to high-quality services and co-ordinated health care? Have the LHINs been able to carry out their mandate better, or should we take them back and bring them back with the ministry?

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Mr. Saäd Rafi: I don't know that we have that slice of understanding, because we don't know what would have happened had they not been in there. I think one thing for certain is that the cohort that CHCs serve is better off today for the availability of CHCs than they would otherwise be because they're oftentimes left behind in terms of the groups that may have the most challenging health conditions and health outcomes. I think the patient cohort is better off. Who oversees them, and is that relevant to whether the patient gets better service? I don't know, actually.

M^{me} France Gélinas: Because, Deputy, when you say things like this, it opens it up to all of the other parts of the health care system that are under the LHINs. If we're not able to say if the CHCs serve the goals of the LHINs to provide better access under the LHINs, then do the mental health agencies do better or should we bring them back to—how come we haven't got any way to tell that it was a successful endeavour to put them under the LHINs and that it has served Ontarians well in the role of better access? If we don't know for CHCs, do we know for the 340 mental health agencies that have been funded by the LHINs for the last six or seven years?

Mr. Saäd Rafi: Fair point. Our indicators would tell us that CHCs—and some, where applicable, mental health—are having an impact, because there are indicators on access and wait times etc. For the role that they fulfill, they're clearly having an impact because they're part of that success. In every LHIN it will depend on where they sit against those indicators. So we're not absent data; I'm just saying that when you asked about the dynamic—would they be better if they were outside the LHIN? We don't know that because they're not.

Are they doing a good job within the LHIN? They are. They are significant players in health links because they represent a cohort of the 5% that, in fact, many primary care physicians may not represent. I would say that they have really increased their rosters in terms of roster patients, so that's an indicator that they're doing better than when they started. There is room there. There is room in the family health teams for more roster patients.

So in the search for a definitive yes or no, in or out, to me there's too many moving parts to just say simply, "You're right on this. You caught me. They would be better out." I don't think that's a statement that we can—

M^{me} France Gélinas: I'm not there to catch you, but you also read the papers, just like everybody else. You have seen the people buying the t-shirts who want to get rid of the LHINs. We have a party that ran an election on the fact that they wanted to get rid of the LHINs. And when the deputy is here, here's your opportunity to shine and convince us that the LHINs have brought value. It makes me feel very uncomfortable to hear you say things like "What is the value added?"

Had we kept mental health directly under the ministry, had we kept the CHCs directly under the ministry and put out money for health links, the CHCs would have been partners in the health links, whether they received their funding and their planning from the LHINs or not. So why are they there?

Mr. Saäd Rafi: First off, I thought this was a briefing on matters of technical content with respect to the LHINs, as opposed to me selling you on whether the LHINs are—

M^{me} France Gélinas: No, no. You're right.

Mr. Saäd Rafi: I think that's an important distinction and that's why I have some discomfort with the opinion-based questions, to be perfectly honest. I think I've tried to express that.

The point being that I don't think you can just simply say that had we just put out money, people would have come and congregated around it. I don't think so at all. I think that the LHINs, by the nature of the work that they have done, are organizing entities to help to bring these parties together.

Health links are an excellent example. These have been driven by the LHIN's assessment, in some cases—in South East and in Toronto Central—of their LHIN by sub-LHIN areas. They have worked quite, quite tirelessly and effectively to bring together the providers, both health and social service providers, that make up the core of a health link.

M^{me} France Gélinas: But I don't want to talk about—

Mr. Saäd Rafi: So they have provided value in that regard.

M^{me} France Gélinas: I agree that the health links have value, but I'm interested in, to the LHINs.

Mr. Saäd Rafi: The LHINs have provided value in bringing those together. I don't think, absent the LHINs, we could have—and I'm actually suggesting that keeping the money within the ministry, we haven't done that since the LHINs have been established. We've been slowly increasing the transfer of funds to the LHINs because there is inherent value, and that value is demonstrated by the confidence that government has shown by giving additional funding to the LHINs, from an original, I want to say, \$18 billion or \$19 billion to, now, just about \$25 billion. So that would be a 33% increase in that six years. That too is a demonstration, to me, of value added.

M^{me} France Gélinas: All right. For the people out there who are not happy with the LHINs—I have heard them; you have heard them. They make their voice quite loud and clear in certain parts of this province. Here's an opportunity to retool. Here's an opportunity to make improvements to the LHINs. I'm asking you for your advice. What improvements can we make that would bring those people who are really unhappy to see the value of the LHINs?

Mr. Saäd Rafi: Well, I want to go back to the example of integration, because I think that is something that could be examined by maybe a change to legislation. I'm not even sure if it requires it. I don't know if it's a regulatory fix that can do that. But we could go deeper into integration, and that's partly why I think, working together with the LHINs and ourselves, we came up with the health link notion. So I would leave it at that. I don't know if others have other opinions.

But when you look at Alberta or you look at BC, this is their third model—for Alberta, maybe their third or fourth model. They had 18 or so, or whatever number they had—13. They went to nine; they went to one. Now I imagine they are going to go to something else because they've completely changed the governance of the single model. Quebec: 18; British Columbia: arguably six plus one, seven. So what's the right number? What's the right model?

I think what is clear is that these are authorities and entities that are undertaking the type of activity that (1) is very important to every Ontarian, (2) spends a great deal of funds, and (3) is very difficult to manage on the ground—well, impossible to manage on the ground—from Toronto. I think even our regional office has demonstrated that their catchment areas were so large that it was very difficult to have a line of sight to the degree that we do.

Now, I would imagine that as a committee you are going to hear input from all manner of sources that will have all manner of opinion and suggestions. Forgive me, but I didn't come prepared to provide the committee with recommendations based on inter-jurisdictional comparisons. Perhaps that's something you'll want us to do at a later date.

M^{me} France Gélinas: Okay. Just jumping ideas completely, in the first presentation we got, it made it clear that the MOUs between the LHINs and the ministry are documents that are accessible; same thing with the accountability agreements. They are posted on the website. Are the accountability agreements between the LHINs and the service providers also available?

Ms. Kathryn McCulloch: Every LHIN site should post all of their—the health service provider should also, but every LHIN site lists all of their accountability agreements with all their providers.

M^{me} France Gélinas: Lists them, and anybody could click on them and open them—

Ms. Kathryn McCulloch: I mean, a link that you would click on and it's there.

M^{me} France Gélinas: It's not through freedom of access of information; it's information that is directly available. Okay.

Do you want—

Ms. Cindy Forster: Maybe I'll ask the question that I actually asked of Mr. Maisey that he couldn't answer because it was a policy question. It's with respect to the guiding principles of the LHINs and providing health care in this province in a non-profit way. He couldn't answer that because it's hard to just—but the question is, has the government moved from those guiding principles? Because it seems to me, and probably to others, that, for example, in the long-term-care sector, nursing home beds are, more often than not, being awarded to the private sector as opposed to the non-profit sector, even though non-profit is applying for those bed licences. So I'm just wondering if there has been a shift.

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Mr. Saäd Rafi: I think, if I'm not mistaken, in the example you're using, those delivery agents, the for-profit long-term-care home providers, were in place prior to the legislation. I think since this legislation was enacted, the government has reinforced its commitment to not-for-profit delivery.

For example, in the action plan for community clinics, it stipulates—and we will soon be issuing a policy guide for a three-year RFP-based approach to various types of services and ambulatory care services in the community—that it will be through not-for-profit providers, and that is defined in the policy guide.

Again, I think that's the change in approach, or maybe the refinement of the approach to the delivery in a not-for-profit model. But it's also interchangeably used as a single-payer system, whereby many systems around the globe—maybe the most venerable of all single-payer systems, the UK, has private sector deliverers, but the government is the single payer, as the government is here.

Obviously, there are private services provided in health care that are not funded through OHIP.

M^{me} France Gélinas: Do you consider a group of physicians owning a practice—do you consider a physician practice as a not-for-profit entity?

Mr. Saäd Rafi: Definitionally, do you know?

Mr. Robert Maisey: I think it depends on how they are incorporated and how they practise.

M^{me} France Gélinas: Can you give me an example?

Mr. Robert Maisey: For example, family health teams, what are called FHTs—I think those are FHTs—are typically not-for-profit corporations. But a group of physicians practising through medical professional corporations in a partnership, those would be for-profit corporations.

M^{me} France Gélinas: Okay, so, a FHT, where physicians get part of their money through capitation and part of their money through billing OHIP, is considered not-for-profit?

Mr. Robert Maisey: The billing in those cases is usually done by the physician directly, so that could either be to him or her personally or it could be to their

for-profit corporation. The organizational structure that we contract with in those cases is not-for-profit.

I think I got my acronym wrong. I think the acronym should be the family health network, FHN, not FHT. I apologize.

M^{me} France Gélinas: The family health network and the family—okay. What about the FHTs? What about the family health teams? Do you consider them as not-for-profit?

Mr. Saäd Rafi: Isn't it a function of their incorporation?

Mr. Robert Maisey: Again, it depends on who the ministry is contracting with and who the ministry is paying. If the ministry is paying the physician directly or the physician's medical professional corporation, then that's for-profit. If the ministry is paying an organization that is a not-for-profit corporation—say, for administrative or overhead costs—then that's a not-for-profit organization.

Perhaps I can take a different example: a community health centre. A community health centre is a not-for-profit organization that typically employs physicians as employees. There's nothing to stop a physician having his or her own office, where he or she sees other patients. In that circumstance, the physician normally would be billing the ministry directly through OHIP, and that would be for-profit.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. That concludes the time.

Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair. I'll start off, and I think my colleague Mr. Colle would like to jump in as well.

Deputy, you've made a few remarks about other provinces, and overall, what I've seen from BC and Alberta is a tendency to go from more boards and regional entities to fewer. I'm reminded of the issue, particularly because we're joined by Mrs. Cansfield, who happens to have a riding where her constituents, in fact, relate to four different LHINs.

I also have had a major health service provider from the Central LHIN in my riding come and talk to me about the need for fewer LHINs. So I guess, just in principle, is there any reason why we would not potentially integrate some of these local health integration networks with each other if the boundaries seem to be problematic, especially in the GTA? Is there any—

Mr. Saäd Rafi: No reason.

Ms. Helena Jaczek: Presumably, the boundaries were chosen for some sort of reason, though they were not apparent to us in the region of York, but there's no imperative to maintain those boundaries, from the ministry's perspective.

Mr. Saäd Rafi: No. Correct.

Ms. Helena Jaczek: Thank you. Okay.

In terms of these 15 indicators that you've referred to in relation to the accountability agreement, you said that you basically assess the LHINs performance against provincial standards or provincial objectives. On what are those provincial objectives based?

Ms. Kathryn McCulloch: It's the provincial targets, and to the deputy's earlier comments, the ones where there are provincial targets largely have been developed by clinical experts, so we relied on the expertise of clinicians in the field to determine what the appropriate target should be. The wait times' ones were national targets, so it wasn't just Ontario that was involved in those discussions; it was across Canada where we have targets—

Ms. Helena Jaczek: And so how often do you look at the provincial objectives and review them to ensure they're current and appropriate?

Ms. Kathryn McCulloch: You mean the targets, you're talking about?

Ms. Helena Jaczek: Yes.

Ms. Kathryn McCulloch: We have not reviewed the wait times targets since the LHINs came into being, mainly because they are national targets. It was a commitment of the federal government, and those are posted publicly.

Some of the other indicators that we've recently added actually don't have targets yet. There is no expert opinion that we have been able to glean that provides us with an idea of what those should be. So we are monitoring some of those as they come into the agreement for the first time, for the first few years, to determine what might be appropriate in the way of a target by looking at performance and what things might influence performance. The various indicators have different ways in which targets have or have not been set.

Ms. Helena Jaczek: Okay. Now switching topic a little bit back to the service agreement with the individual agencies, so the agreement that the LHIN establishes with the various agencies that actually provide patient service. Were the LHINs provided with some sort of legal template so that we could be assured of some consistency across all these service agreements?

Ms. Kathryn McCulloch: The LHINs did assume the ministry's accountability agreements at the time that they came into being. We transferred all of our accountability agreements over, and then we worked, the ministry and LHINs, jointly to develop the first template.

There are three different accountability agreements: one for the hospital sector, one for the community sector, except for long-term care, and then there's a separate one with the long-term-care sector. Those have been developed both with the ministry and LHINs but also with the input, obviously, of the providers as well. They are standard template agreements that have been developed and negotiated between all the parties.

Ms. Helena Jaczek: If the provisions of a service agreement are not met by the provider, what power does the LHIN have to terminate the agreement, or what sort of repercussions are there in terms of non-performance?

Ms. Kathryn McCulloch: It's sort of an escalating process. Obviously the first thing would be a discussion as to why. There may be some factors why indicators aren't hit, as we said, in terms of the LHINs' targets themselves. But it goes progressively, and in the hospital

sector there has been a number of hospitals where they have not been meeting their performance targets, that the LHINs have required them to do performance improvement plans. So they have to come forward to the LHIN, identify where they are going to actually be able to make improvements so that they will hit their performance targets, and it goes right up to—obviously, we have in the past, put in supervisors or investigators into some facilities where the organization has not been able to meet their obligations for a number of reasons. It's very progressive, and it really depends on the individual situation.

1700

Ms. Helena Jaczek: So in the case of a hospital, on the advice of the LHIN, the minister can appoint a supervisor?

Ms. Kathryn McCulloch: That's right.

Ms. Helena Jaczek: Can the minister appoint a supervisor in a CCAC or any of the other service providers?

Mr. Robert Maisey: Yes, with a CCAC and with long-term-care homes. It's not necessarily a supervisor, but where there are quality issues, the ministry has the power to take over the licence, appoint an operator in place of the licensee.

Ms. Helena Jaczek: And in the case of community mental health?

Mr. Robert Maisey: We don't have the power to appoint a supervisor in the case of community mental health. Typically, I think it's fair to say the progressive performance management system has the organization working with other organizations that are successful, or funding is terminated.

Ms. Helena Jaczek: The ability obviously to terminate funding on the advice of, presumably—on the LHIN for the scope—

Mr. Robert Maisey: Actually, in that case, the LHIN would be terminating the funding themselves because they hold the contract.

Ms. Helena Jaczek: Okay. I understand. Thank you.

The Chair (Mr. Ernie Hardeman): Mr. Colle.

Mr. Mike Colle: Thank you. I was intrigued by the deputy's comment about opinion-based questions. I think you are in a place, Mr. Deputy, of opinion-based questions. That's what we do for a living. Most of our questions are based on our opinions. I totally respect your expertise, your professionalism, but just remember that our questions come from our own experience, our own practice in our community and the people we represent, so we are guilty of having opinions. I hope you'll excuse that. I don't mean that in harm, but I just mean it as an interesting comment that you made.

What I would like to say is that I know we're looking at the technical aspects of LHINs and the infrastructure and how they work and so forth. But I think like any government structure, especially in a ministry that is as large as this—this is half of our budget. I think it's probably the largest Ministry of Health in North America. Is it?

Mr. Saäd Rafi: Well, in Canada.

Mr. Mike Colle: One of the things that I think is a bit of a disconnect is, because it is so large and because, again, we are victims of our own success because I think we offer just such a cornucopia of services in our health care system that is beyond anybody's imagination, especially if you come from south of the border or even some European countries—it's really difficult, as an MPP who has been at this for a few years and as a citizen—or a health care provider sometimes—to basically understand what questions to ask and to evaluate where the system is working well.

I think where the real gap is—and it's not because of a wilful denial of duty by anybody or people going in the wrong direction. It's just that basically, like I've said around this place for years, the trains keep taking off to a certain destination and nobody ever stops to say, "Well, before you take off, do you have enough supplies? Have you told people where you're going? Why you're going? What you're going to do?" But the trains keep taking off.

What I think would really help in terms of the accountability of the LHINs and the CCACs and others is if there would be a more conscious effort—and I know there's an effort of public outreach and there's a conscious effort of inviting us as MPPs to come, and talking about stakeholders. There's got to be, I think, a more comprehensive approach to making people better understand—I'm not just talking about the patients and the citizens that need health care, but all the different players in delivering health care, that a lot of them sometimes feel frustration in dealing with the LHIN or dealing with a hospital or dealing with a family health team, because they don't quite know who to ask or where to get answers, because it is extremely complex.

As an MPP, I just find it—the physiotherapy change is one perfect example. I've been dealing with LHINs and I've been dealing with CCACs on this for the last number of months. What would really help is if there was a concerted effort, through the LHINs perhaps, of having an information function or an information office, because a lot of people I run into don't even know that there are community health centres in their community. They have no idea unless they're referred to it by a friend or by a social worker or by an MPP. I find a lot of MPPs don't even know there are community health centres and what they do.

Or I get people coming to me and saying, "Well, I don't want to be part of this new thing called nurse practitioners. I want a real doctor." I say, "Well"—and I have to try and explain to them the value of nurse practitioners and how good they are and so forth.

So what happens is, this basically, I think, ends up costing the LHINs, in their operational budget, in terms of time and communication. It's much more fraught with controversy because the communication isn't done. The outreach, the linkage with the community, isn't done in a comprehensive way on an ongoing basis, whether it's an MPP or a city councillor or a local nurse or a local nursing home, so they can visit or interact with a place, physical or otherwise—it could be digital or virtual—

where people could get some answers to get through the system. I'm saying not just patients; I'm also talking about all the agents and the individuals that deliver health care through the system, because if I'm going through the list and I'm saying—no one in my community, very few, except the people at my hospitals, know what LHINs and CCACs are. They have an idea if they get sick. Primary care physicians: "What's a primary care physician?" Family health teams: "What's a family health team?" "What's a community health centre? What's a nurse practitioner-led clinic?" It is extremely difficult to ensure that the LHINs operate properly with proper input if nobody knows how to access them and access their structures or how their structures even work, because it is extremely complicated.

So I wonder, am I missing something that I haven't found out, that there's a place where people, ordinary folks or ordinary MPPs, can go to and get some good, solid answers and information and clarity on some of these complex issues that we deal with on a regular basis?

Sorry for the long preamble, but if you can try and answer that the best you can.

Mr. Saäd Rafi: Well, first, I would say I didn't mean to imply that you shouldn't have opinions. What I was getting at is that our role is not to engage in opinions but to engage in advice based on research and evidence, so I think that's an important distinction.

With respect to communications, every LHIN should be talking about the work that it's doing in its community and communicating with every one of its MPPs, either inviting MPPs to sessions, inviting MPPs to board meetings, inviting MPPs to learn about what's happening in that LHIN. And if they're not, and if there are examples, we can certainly follow up with them and see that that's either improved or that's done.

Secondly, when it comes to the actual delivery of the service, that's predominantly in the community, either through the hospital, the CHC or the community care access centre. So there are a multitude of resources available to individuals, be they family caregivers or patients. One example would be that some hospitals, especially large hospitals, might have dozens of CCAC case managers there to work with patients prior to discharge, to work with clinicians prior to discharge, to ensure—

Ms. Helena Jaczek: Dozens?

Mr. Saäd Rafi: Yes, dozens—the services that they receive in their community.

We heard in the long-term-care public accounts that there are some hospitals in the north that might have up to some 30 CCAC case managers working out of an academic health sciences centre to make sure patients are properly placed with the services that they need.

Plus, each LHIN would have websites. They would have communiqués that go out. I think one of the toughest things to get across, in my own experience, with respect to change or to understand what's available is communications, so you've hit on a subject that is always challenging, to make sure that everybody has the same amount of information.

In addition to that, government has put in a fair amount of investment in such things as—

Ms. Kathryn McCulloch: Health care options.

Mr. Saād Rafi: Thank you—health care options where, by entering your postal code, you can understand what services are within your catchment area, be that a family health team, a nurse practitioner-led clinic—and some people actually quite like nurse practitioner-led clinics, but you're right, others want a "real doctor," as the saying goes and as I believe you said. You can access your care in that way. You can access where community clinics are with respect to some of these ambulatory services, what hospitals are in your area. In addition to that, when there have been various vaccines available or seasonal shots such as the recent campaign for the flu shot, the government has increased the scope of practice to various providers—for example, 2,000 pharmacists now have been trained—and they communicate through their means and methods.

1710

Mr. Mike Colle: Thank you, Deputy. I agree that's happening.

The real problem is, though, that when you get into a situation where you're dealing with a CCAC resource worker at the hospital or a case management worker, you're in the system, and you're sort of caught with a crisis in your family. But I'm talking about just a better understanding, even before you get to that stage, of what's available. As I said, there's so much going on, and there's so much delivery that's manic because it's urgent care in many cases, that there isn't a real sense that there's this communication available to ordinary people.

They can invite me as an MPP all they want, and I can go to the meetings, but that doesn't help in terms of communicating with my 140,000 constituents in terms of what's available in the greater Toronto area, in the LHIN area, and I deal with two LHINs: Toronto Central and Toronto LHIN.

But anyway, I don't think that's there, and that's causing a lot of damage, I think, to information linkages, those lines of communication, because there isn't this overall understanding of what the partners are all doing. Many partners don't know what's going on.

I can just imagine different parts of Toronto that I represent—they don't know, well, St. Clair West Services for Seniors has a nurse practitioner-led clinic. People are coming to my office saying, "Where can I go to a doctor?" They don't even know that that exists in their community because St. Clair West Services for Seniors, which has been around since 1953, doesn't have the time or the resources because they're too busy dealing with bedbugs or dealing with mental health issues to reach out to people, because they're also very busy with trying to access funding programs that are out there to meet the needs that they see in the community. They're occupied.

I just think there's got to be—maybe the LHINs should do it, maybe the CCACs should do—an on-the-ground way of letting the public in all our communities,

through the LHIN boundaries or whatever, know what's available in the health care system, how you access it—the options.

Again, I was just really angered when I heard these people criticizing nurse practitioners because for years, we tried to get them here. They're saying, "We don't want the nurse practitioners. We want real doctors." I said, "Well, you don't even know what a nurse practitioner is."

That's where I say we need to have maybe the LHINs looking at this in terms of—and I'm not sure this is the proper forum to say that, but I think that is something that would really help lower the level of anxiety and confusion which exists within a system that's, I think, doing a heck of a job providing health care 24/7 in every conceivable situation. I've got two perfect examples. Baycrest Hospital, Sunnybrook Hospital, St. Michael's Hospital, the work that they do and the street people that they treat and the mental health issues that they treat and the seniors who are being treated around the clock and trying to get them care at home—I mentioned the other day here the needs in the psychiatric wards in the big city. I don't know how they handle all of these things, because families can't handle them.

I just think what I see, through my years of experience, is missing is—because the trains have all taken off, and nobody's given the conductor—

The Chair (Mr. Ernie Hardeman): Thank you very much, Mr. Colle. Your time is up.

Mr. Mike Colle: You agree that you've got to slow the train down?

Interjection.

Mr. Mike Colle: See? There you go again. The train's taking off; you won't stop the train. You proved my point.

The Chair (Mr. Ernie Hardeman): Well—

Mr. Mike Colle: I was just joking. It's okay.

The Chair (Mr. Ernie Hardeman): A good point, Mr. Colle. I'm very glad to see that you recognized you were just a train going—

Laughter.

The Chair (Mr. Ernie Hardeman): The official opposition: Any further comments?

Mrs. Jane McKenna: Just so I'm not belabouring Mr. Colle, but I was very grateful that you said what you said, because, Ms. Brown, when you actually said what the LHINs were doing for the seniors, in effect to the physiotherapy or the cataracts, I wanted to say that I can only speak for my constituency office and the anxiety from the seniors. I'm not even an anxious person, and my anxiety—I have someone who has worked here for 11 years, who knows every nook and cranny, and we could not get the proper answers for these seniors. So I'm only speaking for myself; I will not speak for anybody else. We went above and beyond to help these seniors out with their fear. Why we have to instill in the most vulnerable people in society that have paid their taxes their whole life that they just couldn't get an answer—all I'm saying is that if we take away anything from today, I would have

given my right arm to have the information that you said was going out to all of our places, because I can say that mine did not. It wasn't until finally my guy, exhausting every avenue, got the answers. That's all I'm going to say about that today.

Thank you so much for coming, and we're passing. That's it for us.

The Chair (Mr. Ernie Hardeman): Okay, thank you. Ms. Gélinas?

M^{me} France Gélinas: I just want to know, Chair, are we going till 6 or do we save time on the clock to look at our calendar like we had said we would?

The Chair (Mr. Ernie Hardeman): Obviously, this part goes on until such time as we're finished talking. As to the rules of the subcommittee—as I said when we started, we started in 20-minute rotations, and as long as that goes, we can't go any further. Obviously, we don't have to adjourn the committee if the discussions are over with the delegation. But I can't stop the—so you have an opportunity to further question the delegation.

M^{me} France Gélinas: But if you're speaking in code right now, if I don't ask questions, then we will look at our calendar?

The Chair (Mr. Ernie Hardeman): That's up to the committee, but I can't forego what the rest of the committee members will do as to being finished with this debate. I don't have the power to cut it off.

M^{me} France Gélinas: I'll try one quick one.

You are all very knowledgeable about the system. We are on our first day of hearings to look at what went right, what went wrong, how do we make this better? Is there something to salvage? Do we throw it out? We're just starting.

If you were in our shoes—no, I'll phrase that otherwise. You are knowledgeable people. Give us your best advice as to what should be the way forward.

I'll start with you, Deputy. What's your best advice?

The Chair (Mr. Ernie Hardeman): Thank you very much for that. Was there a question in there?

M^{me} France Gélinas: Yes: What's his best advice?

The Chair (Mr. Ernie Hardeman): What the best advice was?

M^{me} France Gélinas: Yes.

The Chair (Mr. Ernie Hardeman): Okay. We'll leave it to the deputy.

Mr. Saād Rafi: I don't believe I've come across anybody in the sector who has been a practising administrator/clinician or clinician or otherwise in four years who has said that there is not enough money being spent. So that means that there is an opportunity to continue to find value. To me, value is a simple formula of quality divided by cost. So some of the things that have been undertaken need to continue, which is evidentiary-based changes in areas of quality to either add emerging services, emerging technologies, or remove those that have been demonstrated, evidentiary-based, to no longer be providing positive outcomes to patients, and to continue to find efficiencies and improvements in how—again, the word integration will come up—services are delivered,

planned and funded in a way that continues to squeeze out more and more services for the same amount of spend. So spend the same, spend better with better outcomes is, I think, a reasonable expectation. One response to that would be community-based clinics in terms of ambulatory care.

I think that as we grapple with the burgeoning impact of demographics, given our geography, in some cases we have very high-density locations and in other cases we don't. That impacts how services can be provided and delivered.

1720

I would say we need to continue it in that regard, and at a sub-LHIN level. Health links, to me, is that example. We can moniker it any way we want—any way one wants; pardon me—but providing care to the most vulnerable will squeeze out better outcomes. Better outcomes will bring savings. Savings will get reinvested. Ergo, there's enough money in the system.

I would say that if people don't want, like you said—both parties have suggested that there should not be LHINs. Then I think one would logically ask the question: Who will have the on-the-ground, local interaction to plan, fund, integrate, and other services that you may feel are necessary that are not being provided by the limitations of a piece of legislation that's seven years old?

I mentioned a few earlier, and I would add some of those examples now. The benefits that have been wrung from the system are as follows: You have the most efficient hospitals in the country—some have argued, in North America, but certainly in the country. You have comparisons to HMOs, the US model of HMOs, such as Kaiser Permanente. They have far fewer—they have nine million patients, so a nine-million catchment area; we have a 13.5-million catchment area. They have 37 hospitals, I think, and 17,000 physicians; we have 154 hospitals and we have 26,000 physicians. They spend \$49 billion; Ontario spends \$49 billion.

I think we have to look at how we deliver services, through what channel of delivery, to use a private sector phrase. I would say that access to community care and access to family physicians has also increased. Wait times have been monitored and, in the main, meet or exceed their targets.

The glass is half full in that regard, in terms of performance—that's my assessment against metrics—but more can always be done.

M^{me} France Gélinas: Anybody else? What's your best advice for us?

Ms. Catherine Brown: I would concur with what the deputy has said. I think the one piece, when I listened to the conversation today—there has been lots of commentary about boundaries and changing boundaries. There will always be a boundary, whether it's the boundaries of the province or within the province, whether it's a hospital's boundaries or a LHIN's boundaries. I think there are many things that can be done that are not necessarily related to retooling the legislation but thinking differently, based on that evidence, about what the best

way is to have those dollars follow the patient, and that's not necessarily a legislative fix. We learn about that, as the deputy pointed out, based on outcomes. We learn about the best ways to do that.

I think the other piece I would suggest is the ability to think about what variables impact things like wait times, for example. One of the examples that—as many of you know, I am relatively new back to health care—and the hip and knee piece—the wait times can vary so much, only to learn that patients defer their surgery. Patients say, “I’m waiting for Dr. Smith, and I’m going south for the winter, and I’d rather do it in the spring.”

Considering what those hard-and-fast drivers may drive, that is not the intended outcome. That is not the best outcome, necessarily, to force someone to go to have surgery at a time and a place when they choose not to.

Thinking about when we set those rules, there was discussion of putting harder or faster rules into the legislation. I think, as Kathryn McCulloch pointed out, it's a permissive piece of legislation, and that was intended at its outset, to allow government the flexibility to make changes based on outcomes and evidence. I think that's a valuable aspect of how it was set up originally.

M^{me} France Gélinas: Any advice, Ms. McCulloch?

Ms. Kathryn McCulloch: I think, again, to sort of support what the deputy said, there's always going to have to be some kind of a regional, local presence. I think that's something that, clearly, from what's happening across Canada, we've all recognized what it looks like. It can ebb and flow, it can expand or shrink, but there has to be a presence on the ground that understands the local needs, particularly in Ontario, I think, because it's such a vast province with such different geography.

The other piece that, certainly, we talk about a lot within the ministry is around the community and the capacity of the community to be able to support where we're going in terms of the health care system and where we need to go, perhaps, in serving seniors and putting supports. Those two pieces: How do you get, locally—understanding the community and what your community providers can provide in the way of support? As a system and as LHINs, or whatever that regional authority might be, how do we support those community providers and the capacity of the community sector to be able to step up and fulfill the expectations that I think we increasingly have for that sector?

M^{me} France Gélinas: Mr. Maisey?

Mr. Robert Maisey: I go back to your opening comment, which was around you coming to this for the first time today, and you asked advice around questions. I think the questions that you've been asking today are a number of the big questions to be asked around boundaries, around what a regional model looks like—we've done one in Ontario before where it was a ministry-driven model; this one is a different model—around who should be under those regional models and who need not be, for whatever the reasons may be. What are the performance metrics? How do those change? How do those get communicated?

M^{me} France Gélinas: Thank you.

The Chair (Mr. Ernie Hardeman): That's it?

M^{me} France Gélinas: That's it. I'm saving time.

The Chair (Mr. Ernie Hardeman): Thank you very much. Then, back to the government: Ms. Jaczek.

Ms. Helena Jaczek: I'll just start off, and I think Mrs. Cansfield would have some as well.

The Chair (Mr. Ernie Hardeman): That's fine.

Ms. Helena Jaczek: Just to get back a little bit to what Mr. Colle was talking about in terms of communication: Certainly, I would say, over the six years since I've been elected, which corresponds pretty much with the establishment of LHINs, I've seen tremendous progress in terms of the way I'm being communicated with by the LHIN board chair and the LHIN CEO. They tried in the Central LHIN. The first crack was a breakfast for all MPPs at 8 a.m. or something—when we were supposed to be in the House at 9—up in Markham somewhere, and 17 of us expected to attend. Now I get, pretty much twice a year, a visit from the board chair and the CEO, so I'm finding that that communication has dramatically improved.

But I guess I'd like to go back a little bit to what the LHINs' communication with the public is and what is required under the legislation. As I understand it from Mr. Maisey, it's essentially that they must have a website; board meetings are open to the public, and the assumption is that the agenda goes on the website.

Having said that, I have heard from people, actually, from across the province, that quite often the community is unaware of the potential for an integration or an amalgamation of services. The community is not aware and they find out way too late and, naturally, they are sometimes quite concerned about services being provided further away from their home. It's the natural kind of reaction.

If the legislation has a provision that there be a website—I mean, I would like to see that, somehow, that be far more generally known, that changes in health care in your local area are under the auspices of this thing called a LHIN; they have public board meetings; this is on the agenda this month.

How would you see that kind of more open dialogue with the community? Presumably, we wouldn't need legislative change, but how would you ensure that our constituents understand more about what's going on?

Ms. Catherine Brown: I'm not sure how to answer that, how would we ensure more, but we can certainly remind the LHINs.

I will say that in addition to their websites, we work with them on communications on a regular basis as decisions are made by the province to change something, to do something differently, to add something new. We work with them locally on how that information is provided. They share with us regularly. We know their minutes are made public and their board meetings are open, but they will often share with us when something has taken place that may be locally contentious or raise concerns. So from where I sit, it seems the LHINs are

doing much of what—certainly if not all of what—they're required to do, but to your point, it doesn't necessarily have to be legislated.

1730

I think, no doubt, you will hear from the LHINs themselves at some point. I think they would be in a better position to tell you what they are doing locally to reach out to people—not that you're not people—not just to MPPs, not just to service providers, but to the people in their area. I believe most of the LHINs, if not all of the LHINs, on a regular basis have opportunities for the public within their area. Perhaps not, as Mr. Colle suggested, a general one-on-one on health care, but as things change and as things are evolving, they would be in a better place to tell you what they do on a—

Ms. Helena Jaczek: So you basically suggest to them, “Put out press releases to all your local media”—

Ms. Catherine Brown: We work with them whenever we're doing something like that to share with them communications, questions and answers and information. They also make decisions locally that they communicate and share back with us, that they're making an announcement or will be providing information locally.

To the question earlier: They share that with one another, to say, “This is how we've communicated that in our area. You may want to base your information on what we've provided,” and upload that to their websites.

Mr. Saād Rafi: I would say that we all understand there are traditional forms of communication, because I think you've said that that isn't always picked up by people in their day-to-day lives, but they have undertaken town-hall-like activities on initiatives all across their LHIN, and they do so on a regular basis. Now, it's not for everything they do, of course, and one might argue, “Well, they're not hitting the people that they should be hitting.” That may be true, but it's not from a lack of trying. Communications is something that always can be improved, and you all know better than I that you can never do enough of it.

Ms. Helena Jaczek: So in other words, the general direction from the ministry to the LHINs is, “Make sure your community is aware as much as possible as to our activities.” Presumably they have some index of suspicion if it's going to be a controversial kind of situation, that they get out in front of it.

Mr. Saād Rafi: But community engagement starts with the legislation and goes right through all of their instruments and requirements. If the point is about their performance against those requirements, I would accept that, as you said, there's improvement there, for sure—always.

Ms. Helena Jaczek: Mrs. Cansfield has questions.

The Chair (Mr. Ernie Hardeman): Ms. Cansfield.

Mrs. Donna H. Cansfield: Thank you very much. Thank you for the opportunity to ask a couple of questions, as I'm not a regular member of this committee, but obviously in having four LHINs and four CCACs, I have a great interest in looking at some of the challenges and obviously some of the opportunities.

It seems to me that sometimes when we look at these issues, we look at them at 40,000 feet, as opposed to where the rubber really hits the road, which is in the communities and in the constituencies, some of which you've heard today, and that is the misunderstanding or the lack of communication or whatever you wish to call it between the physiotherapy and actually what is happening in those long-term-care retirement homes and in the community. Trust me, they're not jibing. Ms. McKenna is not the only one who is struggling with this.

For me, the interesting part is that, even though the LHINs have the same mandate, they interpret it 14 different ways, and so you have a real disconnect. They do not talk to each other. I'll give you a good example: Try palliative care, end-of-life care, and how they deal with it in each of their respective LHINs. It is quite different, and yet the motion that was put forward in the House—I know it, because I put it in—actually spoke to a similarity of care right across this province, and that has not occurred. That's the challenge.

I look at your issue around chronic care. I understand and know the 5% issue you've got, but the interesting part for me, when you talk about an integrated approach—and I'll give you an example of someone who's in an extraordinary chronic care situation; it's costing the system, I guess, a great deal of money. She can't walk but she lives in a basement. So housing is an obvious issue around care and around making sure that individual—and yet, those two, health and housing, had not connected for that individual.

For me, looking at the LHINs means having an honest assessment of what works and what doesn't work, and how you improve it, and I think we need to look at some of the basic things, such as the fact that most major operations occur in downtown Toronto, whereas the patient lives in Etobicoke, St. Catharines, Welland, Bruce county or wherever. Those two folks don't talk to each other, but if they do it's typically five days apart, and you've got a real problem, because then the family is in crisis. They're in crisis to begin with when there's an operation, unless it's something that they're used to.

Part of what I would ask you is the same thing France has asked you. You have to be able to say, “Look, for seven years we looked at this. This is what works, this is what is not working and this is what we need to change, especially in a system as complex as this.” We've all had people who have come after 25 years; I've had folks say to me, “I can't navigate the system,” and I'm in it—I'm in it, and I don't know what to do. I think we have a problem, if that's the case.

I never get to see one of my LHINs. They just don't bother with me, because it's that part of my riding—as if it doesn't care, and yet the service the person receives in that top end is different from the service two blocks away. How do I explain that to my constituents? I can say, “Oh gee, Toronto gets \$170 per person or \$180; poor little old Mississauga Halton LHIN only gets \$110.” Sorry, they don't care. What they care about is that if Mrs. Jones gets this service, why doesn't Mrs. Smith get

this service? They live in the same area. That's a real challenge with the LHINs.

That's part of what I think is our responsibility: to get at, get under and get to it, and say that if this is a system you want to work, then we've got to peel back the onion and have a really good look at the governance. We need to look at the funding. I don't disagree with you; if money was the issue, we would have solved it a long time ago.

We just have a system that isn't quite jelling and working. It isn't as integrated. They don't even use the same forms—did you know that? One CCAC doesn't use the same forms as another CCAC to transfer that patient.

I have accountability agreements where three quarters of the way through a year, a CCAC goes bankrupt or has no money. You guys bail them out, but the question is, should they have two-year funding? Not everybody turns 65 in a year, so their seniors change, right? It's over a two-year period.

They used to say you couldn't get people pregnant in lots of 20 for kids 20 in a class; it's no different with people turning 65. They do that throughout the year, and do we accommodate for that? Do we look at an integrated system?

I'm going to use this, and I've used it before: The LHINs tell me time after time that they do not have the autonomy you say they do. They do as you tell them to do. What's fact or what's fiction, I don't know; I can't seem to separate it out, but I do know that you took the aging-at-home money and put it into acute-care bed release and acute-care bed return. I understand that, but what it did mean was that I ran around telling everybody about aging-at-home money that didn't exist.

How do we go back to our constituencies and deal with this if we don't have the facts in front of us with which to deal? How do we find a way to really improve this system if, in fact, we're going to have a number of people that will turn 65—what is it? I think it's 1,600 a year or every so many months within the next few years.

In my riding alone, in Mississauga Halton LHIN, the number of people who will turn 85 will grow by 71.2%. My question is, are you prepared for that? I don't get an answer. For how many years, of the 14 LHINs, only five had an aging-at-home strategy. They didn't have anything to do with their seniors. That's the inconsistency that I see in my four, and I suspect you might see it across the LHINs.

I just share this with you because I really think you have the opportunity to work with us to make a difference. I'm not your biggest critic, probably, but I'm actually offering to help you make the system work, because if it doesn't work, it will implode. It will implode by the sheer numbers of the demographics, because you can't handle that number of people who are aging as fast as they are unless we change how we do business in this province in terms of health and the LHINs. Again, I only have four, so I can't speak to the other 10, but I can tell you that my four aren't working all that well. They do some things okay, some not, but they sure don't all work together, where my population all lives in my same area.

1740

So, yes, there will always be a boundary. I appreciate that. I come from the school sector. That sucks. However, four of them dissecting a constituency really sucks, because they don't care, as I said earlier. I can't say, "You're in Mississauga-Halton." They say, "What in the hell is that?"

The last I'll share with you is about communication. When you need the health care system, typically, you're in a problem. The last thing you do is go on the Web to find something you can click onto. I'm sorry; it doesn't work that way. What you do is you phone somebody and say, "What do I do? Where do I go? Who can help me? How do I navigate this?" I thought we put money in for navigators. Remember that? That didn't work out all that well either, because the CCACs just sucked them back into the system.

We haven't even touched the whole issue around long-term-care placement and all that stuff with LHINs.

I won't come back because I'm a difficult person at times, but I needed to be able to say this to you because it's that important to me. If we don't get this right, we're going to have a really serious problem.

So I appreciate the opportunity, and I do ask you—actually, I plead with you—to give us your advice. Your opinions are important because you know the system better than anybody else. You know where all of the bumps and the holes and the goods and the bads are, and if you can't share that with us and be honest with us—if you need a closed session with these people to do it, do so. But at least give them the benefit of your expertise. There has to be about 400 years sitting here of good knowledge that they could really benefit from significantly. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much.

M^{me} France Gélinas: Can I clap?

Ms. Lisa M. Thompson: That was very well said.

The Chair (Mr. Ernie Hardeman): Anything further from the government side? Nothing further? Well, it looks like maybe that was the benediction. Benedictions usually are just very—but anyways, very well.

I do want to thank you for coming in, but I think as has been mentioned by the last speaker and others before, this is the first meeting, and this was an opportunity to update the committee on where it's going and what we need to look forward to as we're moving forward in this review. But I would suggest that they do—they haven't yet made the list of all the people they wish to speak with, but I would be quite surprised if it didn't include the ministry again, to hear from you, as we're moving forward with this review, your advice and what needs to be done in the future.

We very much appreciate what you've given us today, and we hope that we can collectively work to make it a better system for the people of Ontario. So thank you very much for coming in.

Mr. Saâd Rafi: Thank you.

The Chair (Mr. Ernie Hardeman): Secondly, I just want to suggest to the committee that we have an in-camera meeting to discuss where we go, because we do have to get that—and you're quite welcome to stay, Ms. Cansfield. But we have to set up a schedule, because the House resolution mandates that we meet again next Monday, or at least the first meeting of next week, so we must have some direction for the Clerk to get ready with the committee.

M^{me} France Gélinas: I was afraid you were going to do the rotary thing and send us all out. I'm waiting to look at our schedule. At least we'll have an idea as to what days work and what days don't.

The Chair (Mr. Ernie Hardeman): Okay. Before we can do the meeting, we have to have a couple of minutes to shut off the system for an in-camera meeting.

The committee continued in closed session at 1745.

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**Official Report
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(Hansard)**

Monday 25 November 2013

**Journal
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Lundi 25 novembre 2013

**Standing Committee on
Social Policy**

Local Health System
Integration Act review

**Comité permanent de
la politique sociale**

Étude de la Loi sur
l'intégration du système
de santé local



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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 25 November 2013

Lundi 25 novembre 2013

*The committee met at 1402 in committee room 1.*LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW

The Vice-Chair (Mr. Ted Chudleigh): We'll call the meeting to order, the Standing Committee on Social Policy. We're here to resume our study on the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act, pursuant to the order of the House dated November 7, 2013.

LOCAL HEALTH INTEGRATION
NETWORK LEADERSHIP COUNCIL

The Vice-Chair (Mr. Ted Chudleigh): Today we have the Local Health Integration Network Leadership Council. Robert Morton is the vice-chair. Mr. Morton, if you'd join us, you will have 30 minutes for your presentation. That will be followed by 30 minutes of questions from each party.

Mr. Robert Morton: Thank you, Mr. Chudleigh. It's my pleasure to be here this afternoon.

The Vice-Chair (Mr. Ted Chudleigh): I'm sorry, sir, could you identify yourself for the purpose of Hansard.

Mr. Robert Morton: My name is Robert Morton. I wear a couple of hats. One is chair of the North Simcoe Muskoka Local Health Integration Network. I also chair the chair's council, when the 14 chairs come together, and I chair that group and work as co-chair with the leadership council when the chairs and CEOs come together.

The Vice-Chair (Mr. Ted Chudleigh): Mr. Goebelle brought me up to date on all that stuff the other day.

Mr. Robert Morton: Good. I know. He told me. So you're just back from holidays, he said.

Interjection.

Mr. Robert Morton: So my presentation has been prepared and I believe will be distributed, but I won't stick right to the script. You don't want to hear me just read something for a half an hour, but I'll try and hit the high points and then move into the question periods as we move forward.

Of course, thank you for the opportunity to be here. I'm going to try and give a provincial perspective in my remarks, knowing that the standing committee will be meeting as the months unfold and maybe making a

decision to meet in other communities. If that's the case, then certainly my colleagues, wherever you're going to be meeting, will be anxious to appear before you and give you the local flavour. My goal is a provincial flavour, but I will pepper my remarks with some provincial, but certainly lots of North Simcoe/Muskoka examples.

This is a pretty exciting time for me. In fact, yesterday as I was doing my final prep for today, I thought it would be wise for me to pull out the legislation and have a look at it one more time. What really jumped out at me was under the "objects", section 5(c):

"(c) To engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation."

I have worked in the health system for many years. I stopped my full-time work five years ago. But that is a most important piece, because it's saying that our communities have a stake and now have a vehicle for having significant input into the decisions of their community. That's gigantic and really important, and I'll try to illustrate how the LHINs have tried to live up to the spirit and the letter of the legislation as we've moved forward.

What I'll talk about is a little bit about who LHINs are and how we work. I'll talk a little bit about governance and accountability and give a bit of a perspective on how we've done over the last eight years since the legislation was first proclaimed. More importantly, I'll try to give you insight into ways that the LHINs and their partner health service providers are making a difference for the people in our communities and to share with you the LHINs' perspectives on opportunities to strengthen the current regional system and to strengthen the act that we're working with.

I need to say that the LHINs welcome this review. Whenever you start something as dramatically different as LHINs or the regionalization of a health care system, that's a gigantic change. When we look at the principles of complex adaptive change, we know that you'll never get it right the first time. If you did, you probably didn't go far enough. So this is a very important opportunity for us to take a look at the framework and make adjustments to it in order for the system to continue its journey to be improved.

While it is a review of the legislation, there's no doubt that many will look at this as an opportunity to review the

performance of the LHINs, and of course we welcome that. In this journey towards excellence, to improve the quality in the health system, we can always do better than we've done in the past.

With that, I think it's clear that LHINs play a crucial role in the system. We're required to listen to what our communities have to say, like no one has ever done before. LHINs need to be champions for the needs of our communities and the people who depend on our vast array of health care services.

A key piece of our mandate is holding providers accountable for the care that they deliver. Our job is to make the system work better for people, not just with one care provider but as people move from one care provider to another. Nobody owns the patient. I use the word "patient" knowing that in some cases it's "client," in some cases it's "consumer" and in some cases it's "resident." No one owns the patient.

The other significant shift that comes from the legislation allows us to put the patient first and to engage the patient in decisions about their care, like we've never done before. The act is powerful and has enabled us to do quite a lot in a short period of time. LHINs are making a difference in our communities, and I'll talk a little bit more about that.

How are we making a difference? We're trying to make the system work more like a system. It's clear that we're not there yet, but there have been significant gains. I say that as a health care provider for years, working in various parts of the system: This system is vastly different than it was when I stopped full-time work five years ago and when I started in the health care system in 1979—do the math; I'm 65. We're ensuring better value for money, we're improving access to care, and we're taking a population perspective in promoting equity, one of the issues that has been important for us to deal with.

It's all about change—changing the behaviour of front-line providers: changing the behaviours of professionals, including physicians; having them work in an interprofessional mode rather than as sole practitioners working within their silo. It's changing how organizations work within themselves and across organizations, and it's changing the behaviour of our patients too, though in some ways patients are ahead of us; their expectations of the health system are somewhat ahead of where we as providers have been.

These are changes that are taking time. This is a journey, and from my view we've made some significant progress, but we've got a ways to go.

In my presentation, I have a section on who we are and how we work. I understand, having looked at Deputy Minister Rafi's presentation, that I don't need to review that information, but let me talk to that key point that I mentioned as I began: listening to our communities. One of the greatest strengths of LHINs is our commitment to listening to the people in our communities in every aspect of our work, or the work of the system, because the LHIN is an entity, but the LHIN is also a system. It's that coming together of all of the providers within a jurisdiction, and the LHIN helps facilitate their working

together in better ways. Community engagement is a core value, an object of the legislation, as I read. LHINs have worked together to develop common community engagement guidelines, and each LHIN posts an annual community engagement plan.

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Now, let me give you the scope of this. North Simcoe Muskoka is Muskoka, Orillia, Gravenhurst, Bracebridge, Midland, Penetanguishene, Collingwood, a chunk of the town of Blue Mountains and Barrie. We're one of the smaller LHINs, actually, with just under half a million people.

In order to kind of get a sense of what we needed to do to improve the system, we engaged in a broad community consultation. We recorded how many people were involved: Over 5,000 individuals, over 20,000 hours of dialogue and over 160 organizations were involved. Now, that's an important number because less than half of those are funded health service providers. They included municipalities, they included school boards, and they included the children's mental health providers—a number of people who are in that human services space but who are keenly interested, and their work is keenly tied to the health services system. That process gave us hundreds of opportunities to improve, so we've organized our work and are moving forward on that.

In order to remain true to that community engagement principle, it's a commitment that we have made that every one of our improvement teams or projects will have a person or persons on that team who have lived experience, because we know that if we listen to the patient, we'll get it right. Our successes to date have shown that there is incredible value that comes from listening in ways we never have before to the patients we serve.

The other point that I would make is that LHINs are highly transparent organizations. Our board meetings are all open to the public. Some LHINs, especially those that are spread over really big geographic distances, are using webcasts to reach out to people. We routinely post detailed information about our operations in our reports, in addition to our annual community engagement plan.

Governance: As you're aware, each LHIN is governed by a board of directors that is directly accountable to the minister through the MLPA, ministry-LHIN performance agreement, and the board members are appointed by order in council. Each board has up to nine directors, who bring a rich mix of skills and experience to the LHIN and have a deep understanding of their community. Indeed, one of the strengths of Ontario's approach is that LHIN governors do not come with a hat on, representing a particular sector or community. They come with the goal of representing all of the people in our communities.

The emphasis on the MLPA is on the patient's experience, so our financial sustainability and on our performance. LHINs are measured under 15 indicators, including how long patients wait, how our emergency rooms are performing, rates of readmission and alternative-level-of-care days. As we move forward with a quality agenda, we'll be anticipating that many of the indicators that

Health Quality Ontario have focused on as they've looked at the quality agenda for all of Ontario will be built into those.

What's key, as we look at these measures, is to know that they're not necessarily specifically assigned to a particular organization. No organization, solely, can change the result. Alternate level of care: Yes, those are patient days in a hospital, but the solution to alternate level of care involves families; it involves community support service providers; it involves the community care access centre and the home care program; it involves the long-term-care sector; it involves complex continuing care and rehab; and a whole host of other parts of the system. So to solve the ALC problem requires systems solutions, not just specific agency solutions. So each of the targets that were set were initially set by the ministry. In many cases they were very much stretch targets; communities were a long way from the targets that were set. It's my understanding that the government relied on external experts from across Canada to set those initial targets. As we've made progress on them, we've seen targets lowered. As different communities have a different set of challenges and a different set of providers, we know that the targets may be a little different from one community to another. That recognizes the uniqueness of Ontario.

Our governance structure: Because LHIN board members are accountable to the members of the community we serve and can have direct contact with other health service provider boards, it creates a unique opportunity for the LHIN to work with the service provider organizations at the governance level, in addition to traditional work that has occurred at the leadership or service provider level, to find ways of changing. It is, as I've said, all about change. By working collaboratively with other health care governors, we are changing the way that our health service providers think about their role in the community and the patients that they serve.

I've used the language about the made-in-Ontario solution. Deputy Rafi talked about the other provinces and their approach to regionalization and the number of regions, but what was a key feature in the rest of the country was that they wiped out local governance. Local boards did not exist; we ended up with a superboard with responsibility over a large number of organizations or different parts of the system. In Ontario, we've left local governance in place. So what is its unique role?

When we have these discussions—and our governance journey in North Simcoe Muskoka and indeed the governance journey in the rest of the province in the LHINs is focused in part on how governors continue to play a role. The place that we've landed in north Simcoe, and it's a place that many others are following up on, is that boards of directors have, yes, their accountability, their fiduciary, their strategic and generative—using kind of the new language of governance—responsibility for their organization, but in addition to that, they have a responsibility to the system. So the challenge is for them to find the balance between their responsibilities as governors for their hospital, their community care access

centre, their long-term-care facility, and their responsibility to the whole system.

This is a significant shift for governors and it's part of the change process that's under way. But I think that is an incredible strength, because governors who are committed to serving their community are better able to focus on the patient that we're serving. The real, right reason for doing this is, with due respect to all of my colleagues over the years in leadership positions, it's hard to move away from the status quo. Boards are in a position of a more neutral and governing position that can help us move faster and more collaboratively to new ways.

I'd like to talk more about our communities and how we make a difference for the people and families who receive care.

First point: Geography makes a big difference. I mean, the language of "one size doesn't fit all" was clearly recognized when 14 LHINs were established, that what worked in Toronto wouldn't work in Wawa or London or, and my directions—I should be pointing to Penetanguishene this way. So as we've moved forward, it's pretty clear that there are differences within each of our communities: differences demographically, socio-economically, and there are cultural factors. These all play a role and have an impact on access, equity and efficiency of the system.

For example, in North Simcoe Muskoka, we've recognized that the way in which the system needs to be organized in Muskoka will be very different than the sub-geography of Barrie, a larger urban area. So this model, the LHIN model, gives us the opportunity, within the provincial framework and within the regional priorities and strategies, to respond on a local basis. We're kind of going right back to the legislation, when communities have the ability to set priorities for the communities in which they live.

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How are we doing it? This is about making the system work more like a system, taking these provincial priorities and objectives and making them work locally. It's about breaking down the traditional barriers between providers—who have worked in silos, and indeed we've organized it so that they would work in silos—to improve the experience of clients and patients.

Lots of health care organizations have looked very closely at industrial organization and have found that using Lean Six Sigma approaches to system improvement have really helped us find efficiencies. Indeed, the emergency room work that occurred that has significantly reduced wait times all used that Lean methodology that involved front-line workers and their patients in re-describing how work would be done and then sustaining those gains, using metrics to help us move forward.

When we take that kind of methodology and approach and apply it at a system level, now it's time for us to get the front-line workers from the hospital, from the community and from primary care working together to find those new care pathways and move the system forward. That's where change is occurring.

I bring to the table a really good example of how that approach has made a really big difference for a vulnerable population. Some of you may be aware that in Simcoe-York there's an initiative called the Children's Treatment Network of Simcoe York. It began with a missing piece, and the missing piece was a children's treatment centre, funding for children's rehab services in the Waterloo area: Waterloo-Wellington, KidsAbility in Mississauga, Halton, Erinoak—a bricks-and-mortar solution to provide services for these very high-needs kids.

In Simcoe and York, the community took that funding and said, "We're not going to create another bricks-and-mortar silo; we'll use that money to increase service capacity in schools, in hospitals, in early intervention programs and in children's mental health, and we'll build the tools to make it possible for front-line workers to work across the human services spectrum and do it with a single plan of care." That was an enormous piece of work, but it was all about change, with the patient and family at the centre and with front-line workers informing—as I said, you can't reform a system in a boardroom; you've got to do it on a shop floor. That's the granular nature of the change that's occurring through LHINs as we try and make the system a better system.

LHINs have become very good at learning from each other. In fact, it's one of the topics that regularly occurs at the chair's table and the leadership table when leadership gets together: How do we leverage good things that are happening in one part of the province with good things that are happening in another? I think about the Home First initiative, where we're clearly trying to change behaviours of practitioners from focusing that when a person gets old, long-term care is the only option for them. The first option should be care in the home. So the Home First program, which changed behaviours and reallocated investments into providing a broader range of community supports, more intensive supports up front, has moved lots of people back to home where they should be instead of waiting in a backlog to get into the scarce-resource long-term-care facilities—so, really good things that we've learned from that.

Convalescent care program: All LHINs now have a component of this, and I'll tell you a story. In Collingwood, a small nursing home, they were able to carve out space for four convalescent care beds. I visited it shortly after they opened, and I saw this one—I'll use "little old lady," and she was hanging onto the handrail. She had a kinesiologist beside her, and he could have been her grandson and maybe even great-grandson. He was having her do knee bends while he's holding on and he's kind of supporting her and encouraging her. I saw her a little bit later, after I visited some others. She had a balloon between her legs and he was helping her squeeze her legs together against the balloon.

She had been in hospital. It was a diagnosis of failure to thrive. It was pretty clear that she was on a downhill slide of aging. She really did want to go home, but really needed that jump start. Three months in convalescent care in the long-term-care facility built up her strength

and her capacity and her self-esteem so that she was able to go home. It's an incredible success story that's occurring time and time again. That's a new program, existing resources, but it's a different way of using the resources that's having some really good results.

Access to care: All health care providers are part of an interdependent system. No one provider meets all of the care needs of the people in our communities. I believe that all of these organizations are clearly committed to making it better for the patients, but the reality of their day-to-day operations sometimes makes it hard for them to focus on the bigger picture.

With the LHIN: Because no one hospital or community agency or long-term-care home can make an impact on their own, these improvements that come from engaging workers together to focus on the things that are important for people are a way of moving the system forward.

On the point of equity, LHINs are committed to ensuring that every individual, regardless of their gender, race, income or social status, has the same access to high-quality health care. We've seen across the province great challenges meeting the needs of First Nations and Métis people. A number of LHINs—I look to the northeast; I look even to the southwest—have specific programs focusing on those vulnerable populations that have really started to make a difference as we've brought the system together. Notwithstanding the bigger system problems of federal and provincial jurisdictions, on the ground there's a clear commitment to make services better for some of our most vulnerable people.

In terms of partnerships, because that's what it's all about, LHINs have also established strong partnerships provincially, working with the sector associations, working with research organizations, and very clearly working with Health Quality Ontario, which has a very unique role to play in supporting the quality agenda, giving us the tools and giving us the evidence as we try to apply best practices to our clinical processes.

One of the other important outcomes that the past eight years have shown is that there is an increased level of accountability with service providers to the province of Ontario for the services they deliver. Public dollars are being used more effectively. The service accountability agreements are a better monitoring tool than what was in place before with the previous mechanism. We've seen a significant drop. While health care costs are still increasing, they're not increasing at the rate they were. Indeed, I was reading some recent stats that Ontario has done a better job at bending the health care curve than any of the other jurisdictions have. We have a ways to go. The financial problems that we are facing as a community have not yet been solved, but there are mechanisms in place to help us get there.

I think it's important for the committee to understand that the improved quality of care, reducing waits and delays, results in lower costs. Endless pursuit of quality will result in better care. We won't be duplicating; we won't be readmitting. It is about quality, and so the quality agenda becomes really important to us.

Our ability to manage performance is growing as we get access to better, more current information. Traditionally, we've had very good information sources from the acute care system; the community care system is catching up with that. So as we manage the system, those clinical information points, when they get aggregated, become management information. When they become aggregated to the next level, they become system information. So we're becoming much more acute in our ability to use the data sources that are emerging to help us improve the health care system.

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Are we there yet? No. There are opportunities to improve our health care system, clearly.

The Vice-Chair (Mr. Ted Chudleigh): We have about three minutes left.

Mr. Robert Morton: Three minutes? Thank you.

First, I would talk about giving LHINs greater responsibility for managing the accountability of primary care. I was absolutely excited when the minister announced her action plan that talked about bringing primary care into the rest of the system. Primary care has always been there, and it's always been important, but we never established the links between primary care and the rest of the formal system. Health links gives us an opportunity to do that in a way in which I believe physicians will be much happier about the care they provide. Patients will be much happier. That's a key piece.

I think there's also an opportunity to improve the system by giving the LHINs greater responsibility for managing the accountability of independent health facilities. As we look at moving more and more procedures out of acute care centres and into the communities, into independent health facilities, we need to ensure that their accountability is managed. And so, it will require some changes to the legislation that include IHFs in the range of partners that are involved with LHINs; and for health service provider boards, defining responsibility to the systems, as well as their own organizations.

I talked earlier about the journey that we've been on in North Simcoe to understand the new role of boards. I think we need to take a bit of a step back, look at it provincially and clearly underscore that boards are a very significant part of our system. We need to think about ways of adjusting the legislation that underscores that responsibility, which is a joint responsibility, not just to their agency but also to the system as a whole.

It would help LHINs if we had greater flexibility to allocate funds and the ability to fund initiatives over multiple years. This would be a statement that would be made, I'm sure, in every ministry, but change takes time. When we look at new initiatives, you need to be able to build capacity. You need to move forward, and it would make life much easier—it's not about making life easier. It would ensure the transitions within the systems if we could use the limited amount of new investments in a way that can ensure that there will be sustainability for good ideas.

Then there are administrative barriers, not within the legislation, but within all of the siloed pieces of legisla-

tion that we have. I have to commend the work of the associate minister, Helen Angus, on kind of being the rule-buster—not breaking the rules, but finding ways around those rules that have emerged because of—

Mr. Mike Colle: The what-buster?

Mr. Robert Morton: The rule-buster.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Mr. Morton. We'll move into the question phase. We'll start with the official opposition. Mrs. McKenna?

Mrs. Jane McKenna: Thank you so much for coming with your detailed presentation. We do appreciate you being in here today.

On page 2 here, you have a question saying, "Ensuring value for money so that the system can be sustained for our children and grandchildren." Do you think it is sustainable now?

Mr. Robert Morton: Certainly it wasn't at the rate at which health care spending had been growing. When we compare our spend rates to the spend rates in other jurisdictions, in Canada and Ontario we're spending at greater rates. I think Ontario is doing better than other provinces, but I think we need to get a hold of it in different ways. We need to have better outcomes for the funds that we're expending.

We've had all kinds of money that we've thrown at the health care system. It hasn't turned into better health or better outcomes. In some ways, I think these tough economic times give us more pressure to use the scarce dollars correctly.

The minister talks about the 1% of our health care recipients who are using 34% of our health care dollars. In North Simcoe Muskoka, that translates into about \$120,000 per person. That's not including OHIP billings. The provincial average is about \$116,000. And as we are doing through health links, if you talk to those people, they're not really happy about the health care system. They're the ones going back to the ER time and time again. They're the ones who are going to multiple doctors because they can't get the answer they want. They're not happy with the system. So on a provincial basis, by reducing that cost by 10%, very much an achievable amount, it turns into about a \$2-billion re-investment fund.

So we're spending that money on the system. We're not getting good outcomes. Those people aren't happy. They're not getting quality care. If we can improve their care, we'll spend less money, and we'll have money to invest within the system.

So, bottom line, we are working towards—we're not there yet; we're not as efficient and effective as we could be. But we're chipping away at it, and I think we're making progress.

Mrs. Jane McKenna: When you say "chipping away," you have here that it's eight years you've been doing the LHINs. We were told six and I thought seven, so we're just going to say whatever number at this particular point—

Mr. Robert Morton: Somewhere in there. And I've only been at the LHIN table for just a little over two

years. But the legislation was proclaimed, and there was a start-up period as organizations were established, board members were recruited. It was some time after the legislation was proclaimed that the service accountability agreements were introduced, first for hospitals, then for long-term care, then for multi-service agencies. It wasn't sort of, everybody started out at the very beginning with all of the tools; the tools have emerged over time. There has been some ramping up as we moved forward.

Mrs. Jane McKenna: You keep talking about evidence-based outcomes and measuring. From when we were here with Mr. Rafi last week, Mrs. Cansfield brought up some wonderful points, one being very obvious to me—and I didn't speak for anybody else, but she reiterated that; she's not here today, sorry—about how the system is so hard for us to navigate. How in heaven's name anybody else can, I have no idea. You mentioned today how all 14 LHINs work together as a team and collaborate and give off information so everybody is working at a different level. Well, we don't see that at all here.

I'm trying to figure out, with your presentation here, how exactly, when you have performance measures for each LHIN—where do the targets come from, who measures those targets and who sees the outcomes of those targets? Because clearly, what you're saying right here, "Everybody working together and the people who need help get help," we don't see that at all—well, I'm not going to say anybody else; I'm saying I, as an MPP, don't see that at all. Your system is very hard to navigate. I know you say you go back and facilitate for the people in the community who have told you what their thoughts are, but we don't have any of that communication at all in Burlington. Who are these people from the LHINs going back to facilitate and who has the information that they're getting that from?

Mr. Robert Morton: Let me—

Mrs. Jane McKenna: Yes. I've asked about five questions. Sorry.

Mr. Robert Morton: No, that's okay—they're great questions, and they're really important questions. So let me kind of triage them, in a way.

I think we need to get into our heads that the LHINs play a very different role. They're not service providers. We're there as system managers, trying to hold all of the different partners accountable for what they're supposed to do. The traditional approach that looked at each provider individually—the accountability measures for Joseph Brant Hospital, for the—I'm struggling to think of local examples for you, but actually, I must say that I'm proud to say my grandfather was the founding chair of Joseph Brant, and I remember as a kid the sod-turning and the ribbon-cutting.

Mrs. Jane McKenna: Wonderful.

Mr. Robert Morton: Yes. It was an exceptional time in the 1950s—another indication of age. I digress.

The point is that holding Joseph Brant accountable for ALC is inappropriate, because the resolution of the ALC issues involves many partners. So it becomes that the LHIN comes, on the one hand, with the stick, saying,

"Live within your budget. Manage your accountability. Meet these targets." But it also comes with a number of tools and processes to make it possible for that hospital to work with its partners in degrees of detail that it never had in the past. Hospitals didn't have to work with their partners—they just did what they did, and the people went home—because we didn't have the complexity of problems in our hospitals back when Joseph Brant opened in 1957 that we have now. The people in the hospitals then were very different than they are now. People in the hospital then had acute illnesses; now, most people in the hospital have chronic diseases that need multiple interventions, not just a surgery or—I'm trying to think of the language—patch and repair shop. It's a very different kind of service that we're providing, and people want their care at home.

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So the LHINs bring the tools—the carrots and the sticks—to get the health care providers working together to make the system more effective, so with the gigantic step forward of saying, "Primary care, you're part of the system. Family doctor, by working with your colleagues—physician, nurse practitioner, social worker—at your health link, through your family health team, you now have a broader responsibility for that patient." You can take that on and help them manage, navigate their way through the system. The LHIN can bring to the table the technology supports that are required in order to create that beautifully seamed system. I don't like the word "seamless," because the reality is, there are seams. What we want are beautiful seams within the system to help the patient be part of their care and to move in a coordinated way across the system. The technology, as I mentioned, plays a very significant piece in that journey.

I'll use an example of North Simcoe Muskoka. The hospitals were producing a report. They were printing it and faxing it to the family health team. The family health team staff took that fax, scanned it and then filed it in the patient's report. That took, on average, 16 days. By working collectively, that now takes 30 seconds from the time the report is generated and it's into the patient's EMR. These are gigantic improvements within the system, but it requires us to work together, and that process is rolling out across the province: much better access for the primary care provider to the information that comes from their other partners within the system.

Mrs. Jane McKenna: You mentioned health links and how people are happier, the physicians and the patients, so I just wonder: Because it's patient-centred and that's what we should be doing in the first place, where can we see the evidence-based outcomes where the actual patient is happy with what the outcomes are? I don't want—like it's easiest for us to see the actual data.

Mr. Robert Morton: Yes, I agree. So we've done a good job at developing some patient feedback information, particularly on the institutional side, the hospital—our LHIN was looking at the ER data, but we haven't gotten to the point of looking at system-wide data yet. Long-term-care facilities do client satisfaction. Community care access centres do client satisfaction, using similar

tools that help them compare CCAC to CCAC. We need to move—and this is another step that will come, needs to come, as the system moves forward—to the overall client, sort of their system experience.

In the past, with primary care being the way it was organized, sending out surveys about your family doctor isn't going to help. You don't get that body of information. You don't have the comparatives. You can't move the system forward with that. Now, when we're dealing with teams, when we're dealing with much better sources of clinical data, we can connect information from clients about their clinical results, which will come from the electronic medical record. But we also need to take the next step in getting client satisfaction, system satisfaction, rather than client satisfaction with silos.

Mrs. Jane McKenna: You see, to me, when you're doing your performance for your targets for your LHINs, the only way you could measure their success was by the patient in the system. So I'm just kind of wondering when—because we don't seem to have a good measure of performance of what the LHINs are doing: who's doing what; who's better than the other. But if the key component is measuring the success of the patient through the system, and that's what you're all about with legislation, why is it that you're not able to measure those outcomes for those patients?

Mr. Robert Morton: I would say we're not able yet.

Mrs. Jane McKenna: It's been seven years or whatever. So when is that? Is that not a target that you would want to achieve?

Mr. Robert Morton: It is a target, and I think that adjusting the legislation to make that a clear responsibility would really strengthen the tool and would get us moving even more aggressively in that direction.

Mrs. Jane McKenna: Two questions: If, right now, you had your wish list and you were able to tell us—because ultimately, in the end that's what we're doing here—what you would change in the legislation, what would that be?

Mr. Robert Morton: As I mentioned, as I rushed through my final points, with health links the accountability mechanism is not crystal clear yet. We're talking about agreements that the LHINs will manage for each of the health links. But a health link isn't an entity. It's not a legal entity. It's a collaboration of partners coming together and agreeing to work together in a collective way. So we need to be a little bit clearer about what the tools are that the LHINs will have to manage primary care accountability.

This is about the carrot, not about the stick part of managing. How do we leverage information of best practice from one health link and use that knowledge as we improve the next health link? This isn't about money. OHIP and the negotiations between the government and OMA I don't anticipate will change. This is about how physicians work, and I'm cautiously optimistic that we can move forward on both of these fronts, creating a funding environment—but again, that's a government responsibility; that's not an area of expertise that we would want to go into.

So that's a key piece of it: improving the accountability piece for primary care. Recognize that when LHINs started, primary care was way out there, and it's just in the last year that it's been said that you have to have primary care as part of the system.

The next piece is about independent health facilities. The government has committed to moving certain procedures out of acute care facilities into the community, so diagnostic procedures, surgical procedures—the cataract is a good one. The Kensington Eye Institute is an example that we frequently hear about. IHFs weren't contemplated to be part of the system when the legislation was first passed. As we start to grow and create more and more independent health facilities, we need to make sure that their accountability is managed. So adding that component to the LHIN legislation would help us ensure that they are responsive to the needs of the community and are providing good value for the investments that we're making in them.

The third area is about flexibility. We know, in working with the long-term-care act, the Public Hospitals Act—you know, a whole host of pieces of legislation that have been around long before, decades before, the LHSIA act—that there are pieces in each of those pieces of legislation that say, “You've got to do it this way.” Well, the reality is, we're trying to move to an integrated system and we get a barrier that won't let you do it that way. I'll use an example in long-term-care facilities: Using space for convalescent care wasn't contemplated when the Long-Term Care Homes Act was created. It's easy for a bureaucrat to say, “You can't do that because that wasn't contemplated; it's not in the legislation. You can't have that style of short-stay bed. You can't offer that program because the legislation trumps everything.” So we have to find ways to remove those—and I characterize them as administrative barriers that exist within a number of pieces of existing legislation.

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Mrs. Jane McKenna: So if we spend 46% of monies on health care, and we have a system right now where we can't actually measure the job description of a LHIN—and it's not clear to each individual LHIN what that is; and after seven years, we still are altering, measuring performance levels—to me we have a serious problem. If you have a system and people understand their job description and they go and they do it, then that's great. But when you're still, after seven years, and—Mr. Rafi—you have so many people who are setting these targets and looking—this isn't one individual person who's looking at all these 14 different LHINs.

I guess where I'm unclear is how long is it going to take before we actually can have some form of system in place that people know what they're doing and their performance measures are all at the place where they should be?

Mr. Robert Morton: We have it now through the 15 performance indicators, broken down looking at wait-time pieces, looking at emergency time waits. So those are the common pieces that we have that we can compare one LHIN's performance against another. And I want to

go back: This is about the performance of health care providers within a LHIN geography. We have those indicators. They're being refined as time goes forward. They were very much stretch targets for many of the health care providers in many of the jurisdictions. We've made significant progress. I may not have mentioned in what I said, but the script talks about Ontario making the most progress on wait times of any of the provinces in Canada.

So we do. They don't capture the patient experience adequately; I think that's work to be done. I don't think our indicators are sensitive enough to community variations and the mix that's there, some of the socio-demographics.

I'm really excited by the work Health Quality Ontario has done as it's worked with all of the silos to come up with the next iteration of quality targets, to moving to that common quality agenda. That's a very important step, and I would urge the committee to talk to HQO about the work they're doing on the common quality agenda.

Mrs. Jane McKenna: So do you think that with primary and then having the people stay at home longer as opposed to long-term care, is that because we don't have enough long-term-care facilities for people? And what exactly are we going to do when the baby boomers get into the system? Because we can't cope now.

Mr. Robert Morton: Baby boomers—me—even though I worked for a chunk of my career in long-term care, we don't want to go to long-term care. We want to remain at home. We want to be as independent as we possibly can be. We want the services—and I'll speak as a baby boomer—that I can afford, that I can pay for myself or I can access from the public system, that will allow me to stay at home.

We will always have a need for long-term care. There's still some work to do on the distribution of long-term care. I was looking at some CCAC data over the weekend that shows that there is still a range of beds available for different jurisdictions, so we need to do some work there. We need to recognize that in some parts of the province, particularly the northwest and the northeast, there are real challenges around what's the right mix of community supports, home supports and long-term-care beds. So there needs to be a different answer. There needs to be some capacity work done to understand what the right capacity is.

But on Thursday last, I was in Penetanguishene. The county of Simcoe has really gotten serious about care of the elderly. They've rebuilt their long-term-care facility there. While it was an expansion of beds, they were interim beds that were already in the community. But they've added four other elements of housing to it, from rent-geared-to-income housing with supports, to more of a traditional retirement home, to life-lease housing in both apartment style as well as cottage style, to create this community that serves over 450 people.

So it's a recognition, again, for the baby boomer to be able to go into that semi-independent living environment, to have services provided to me, to use the technology—

as we look at home care, CCACs are starting to introduce the electronic home care monitoring systems. I don't need to have somebody come in and take my blood pressure. I can have something hooked on me that tells the blood pressure all the time, and it can be monitored anywhere. There's a whole host of technologies that make it possible for people to be more independent.

But our long-term-care facilities will clearly need to be there for people who are cognitively impaired and can't manage their own care, people who—and we've seen some horrible outcomes of people with severe behaviours in our long-term-care system, and those are great tragedies. But 80% of the people in long-term care now have some form of cognitive impairment, and that will be a key piece of that system. But I think we need to continue to find better and better models, rather than building more and more beds or bigger and bigger homes.

Mrs. Jane McKenna: So if you could say one thing—LHINs are not a service provider, but they are a system manager. What is the best thing that they have offered for the communities as a service manager?

Mr. Robert Morton: They've brought the partners together to identify the challenges to the system and to create processes for working to solve those problems.

Mrs. Jane McKenna: And you have evidence that those are working?

Mr. Robert Morton: Yes. Every LHIN will have evidence of things that they're very excited about, where they've—I talked about the musculoskeletal, but there are a whole range of clinical things happening all over. There's lots of good news.

Mrs. Jane McKenna: If they're the facilitator of those and you're saying they've done a great job, where can we actually see the evidence that those are what they're doing and managing well as a system manager? Is there some place to see that?

Mr. Robert Morton: The broad indicator is that our costs aren't climbing at the rate they were, even though our population is growing and aging. We've bent the cost curve. We've come a long way at holding the line, and now it's time to really go looking for the gains to bring the curve down even further.

Mrs. Jane McKenna: But how do you measure those curves? I'm just curious. I know you're saying it, but where exactly did these numbers come from? There must be some place where you have some form of facts in front of you so that you can actually see that there is a difference.

Mr. Robert Morton: Well, I was referring to the study that was done by—was it the Fraser Institute or the OECD? It was comparing our health system performance to the others. So it is—ICES, the Canadian Institute for Health Information, all of those bodies that look at data collectively. I'm a chair; I'm not into the day-to-day workings. But that's a question that—as we brief our colleagues, I'll make sure that there are more robust answers than I'm able to give to that question, as the hearings proceed.

Mrs. Jane McKenna: Okay. Do you have any questions? No? That's it for me.

The Vice-Chair (Mr. Ted Chudleigh): Are you finished?

Mrs. Jane McKenna: Yes. Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Good. We'll move to the third party. Ms. Gélinas?

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M^{me} France Gélinas: Thank you so much for being here. I want to start with the comments that you've made on page 3 that I was really happy about. I come from northeastern Ontario. The LHINs are there to give people a voice in the health programs and services that will be available to them. When you come from northeastern Ontario, it's way better to have somebody up there than down in Toronto. What do they know about what we need? We get it.

Mr. Robert Morton: Absolutely.

M^{me} France Gélinas: So you make a comment that community engagement is both your core value and a legislative requirement, and you post community engagement plans, and I follow all this. But we're here to look at how we could make things better. There are areas of the province right now, which we will more than likely be visiting, where people actually got matching T-shirts to tell us how much they hate the LHINs. They know what you do. They do not feel like you listen to them. They do not feel like you engage them in changes. They hate you. How do we move this forward? What can you tell us that will help us bring those people into the tent, that will help us diffuse some of that tension that exists? We're open to your advice.

Mr. Robert Morton: I think it comes in many ways. I appreciate the frustration that you would have as a member of the Legislature when you have constituents who aren't happy with the system.

M^{me} France Gélinas: Not the system, the LHINs.

Mr. Robert Morton: The LHINS, the way in which the LHINs are performing. Dialogue, dialogue, dialogue—you've asked for advice; you need to hold your LHIN accountable for those things that I'm saying on their behalf in this presentation, that we have to engage our communities in our discussions. That discussion, that engagement, has to be done with the health service providers as well. It's not us and them, the health service providers against the LHIN and against the population. We've got to find that common ground. This is about the health system—that's our interest—and that common ground, then, has to be the patient that we're serving. So we've got to work harder to get the patient to the centre of the discussion. What's going to be better for the patient in your riding in the North East LHIN?

M^{me} France Gélinas: The example I was giving was not necessarily just for mine. But this is the core value of the LHIN. This is why you exist. You exist to give people a voice. You exist so that people have a chance to say which programs and services they want. And yet, in some parts of the province, you've failed. There is no other way to describe it. Some people really hate the LHINs. And yet, it's your core mandate. What have you, as a group, learned from this? What can you give us for

the future that will change? You are the expert in community engagement. It has been years that those people are not happy and we haven't moved an inch to bringing them into the tent. They still hate you with more passion than before—not you, the system you represent.

Mr. Robert Morton: Yes, yes. I didn't take that personally, though I guess I do. I have spent my whole career working in the health care system. I'm as excited as I've ever been about the future for the health system. I see higher levels of collaboration. I see more levels of support. I see a much better understanding of the importance of community and patient engagement. I see a much better focus on the patient as being the centre of their care, patient-centred care. We're a long way from where we were. Clearly, based on your examples, we're not there yet in some communities. That doesn't mean we have to throw the baby out with the bathwater. I think we have to hold all of our providers—that includes the HSPs and the LHINs—to the standard, to the legislation, for engaging their communities in the discussion about the future.

Now, they have to be real discussions. The reality is, the existing system is not sustainable. The way in which we have provided care in the past doesn't meet current and future needs. We have to change the system, even though people don't like change. I'm going to use the example of: "What about the doctor who doesn't want to join health links and be that sole practitioner out there? What are you doing about them?" The answer is, well, we've got to focus on where we're going to make some gains. You can't fix everything at once, so let's work with the—in change management—low-hanging fruit. Let's go where we've got some motivations, some energy, some desire to change.

But the reality is, that doctor will change when his patients see that the better way of receiving care is not from the old-style family doctor, working independently, loving and caring for his patients. That doctor would have better tools if they were part of a team and working in a system approach, rather than as a sole practitioner. But that's a journey of change, and our communities have to be part of that journey.

M^{me} France Gélinas: You suggest that we hold all providers, including the LHINs, to the legislation. How would you suggest we do that?

Mr. Robert Morton: With respect, I don't sit in the Legislature. That's what the act is about. I think MPPs play a really unique role. I would encourage you to meet, if you're not meeting regularly with your LHIN and your HSPs, though I expect you are. You need to continually push that agenda. When I go to an MPP's office, it doesn't matter what colour their tie is; this is about the people we're serving. So MPPs play a particular role in communicating with the LHINs about issues.

In my regular meetings with MPPs, "What are you hearing from the community?" is a question that I ask, because it's a good temperature for me. Are they hearing lots about health issues or are they hearing less about health issues? I'm really pleased when an MPP says, as

last week, “No, things are trending down, even though this one hospital has proposed to make some significant changes in order to make its budget. I’ve had one call, but we’re monitoring it. That hospital is working well with its community. It has its engagement strategy out there. It’s supported. They’re giving good evidence for why they’re changing.” So it can work, but it’s hard work.

M^{me} France Gélinas: All right. My colleague before me talked about indicators of success. When you put forward health indicators for success, such as the wait time for cataract surgery went down and the wait time for hip-and-knee went down, it would be pretty easy to say that had nothing to do with the LHINs. The wait time went down because the ministry invested a tonne of money in getting more ophthalmologists to do cataract surgery. Whether you would have been there or not, or not even thought of, give ophthalmology more money to do more cataract surgeries and the wait times will go down.

Mr. Robert Morton: I use the experience in North Simcoe Muskoka, where we didn’t get more hip-and-knee wait time money, but the result of moving from three separate sites providing orthopedic surgery—hip replacement, knee replacement, hips being the more critical one. They each had their own staff of physicians. They each had their own standards of practice. They each served their local community, and if someone from north Huntsville needed that surgery, then they kind of had to wait-list against the program. By creating an orthopedic program that used the three hospital sites, that moved them to common standards, that put in place a bed registry which made sure that in the emergent case—a person falls—they get their hip replaced within 24 hours, there were incredible gains in that system, because we got rid of the waste, we got rid of the waits, we got people working together. As a result, without an investment in a whole bunch of new hip-and-knee funding, we used what we had in a more effective way. That’s the kind of change that needs to occur.

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M^{me} France Gélinas: There are 14 of you right now. If you look at the geographical boundaries, you are an example of a very small LHIN, with half a million people. Do you figure the boundaries are at the right place? Do you figure the number is the right number?

Mr. Robert Morton: It’s an interesting question. When LHINs were created, it was clearly stated that the boundaries shouldn’t be boundaries for people; they’re really administrative boundaries. For example, in North Simcoe Muskoka: Parry Sound is technically in the northeast, but 60% to 70% of the people in Parry Sound, when they look for other services, are getting them from North Simcoe Muskoka. It doesn’t matter. For a patient, the LHIN boundary shouldn’t be a boundary to their access to service.

M^{me} France Gélinas: I’m asking you administratively, is 14 the right amount? Are the geographical boundaries for the work that you have to do—did we get it

right? Does it need any changes? Do you have any suggestions?

Mr. Robert Morton: I think, by and large, we got it right. Lines were drawn on a piece of paper. They were based upon hospital utilization. Hospital utilization changes over time. Hospital utilization is only an episodic use of the health care system. People use other parts of the system on a continuing basis. I think any boundary change would have to be weighed against the impact that forcing reorganization and restructuring of the rest of the system would create. On balance, I think, we have a model that can work because we’re not creating barriers for people in crossing the boundaries, that we can make it work.

M^{me} France Gélinas: As far as you know, there are no areas of the province that would really like to see a LHIN boundary change?

Mr. Robert Morton: Personally, I’m not aware of any, though there may be. I’m not aware of any.

M^{me} France Gélinas: Okay. If we look at the part of the health care system that you fund—whether we look at CCACs, CHCs, long-term care, mental health etc.—did we get that right? You do mention on page 11 that I think you would like to have funding ability for more of the primary care sector. Would that be limited to—

Mr. Robert Morton: Well, I—sorry, I interrupted.

M^{me} France Gélinas: Go ahead. What did you mean by that?

Mr. Robert Morton: When we talk about the primary care sector—remember, when LHINs were established, primary care was another part of the ministry. It was funded in a very different way. There was a great deal of energy spent over time to change the funding models—negotiations between government and OMA. We talked about FHNs, family health networks. We talked about FHGs, family health groups. We talked about FHOs, family health organizations. And then we sort of landed on FHTs, family health teams. So there’s lots of work going on there.

Let me talk just a little bit about community care access centres and I’ll kind of bring the things together. Community care access centres were started in the late 1990s. It recognized that if we wanted to have an improved health care system, we needed to have a consistent framework for home care delivery across the province. While we did have home care across the province, it was very different. In fact, the spend rate was 4 to 1. Some parts of the province were spending four times as much as other parts of the province. Part of that came from the structure of home care.

M^{me} France Gélinas: And to my question?

Mr. Robert Morton: Yes, I’m getting there. So they were very different. When CCACs were created, moving from either a hospital-sponsored, a municipally sponsored, a health-unit-sponsored or a stand-alone-agency-sponsored, to create kind of a single model, more like the hospital model for governance of that part of the system, it would have been really good at that time if we’d been able to bring primary care into that part of the system,

because primary care and home care are absolutely related. But it could not have happened. Primary care wasn't at a place in time that it could have allowed—the age demographic, the understanding of the critical mass of physicians about the value of interprofessional care wouldn't have made it possible for us to bring primary care into the system.

Now the time has arisen. It's not about funding primary care; it's about managing accountability. If a health link says its goal is to keep people out of emerg; to deal with the complex people; to drive the cost of the 1% down by some target, so we have money to reinvest in the system, then it's about managing their performance. Working with them to manage performance rather than funding primary care is the basis of this request. It's a big challenge.

M^{me} France Gélinas: Why wouldn't that principle apply to everybody else? You just need to manage the accountability of a hospital; you don't need to fund them. You just need to manage the accountability of long-term-care homes; you don't need to fund them. Why is primary care so different that you can manage the accountability without funding them?

Mr. Robert Morton: Funding is a good tool to use to get there. I'm just suggesting that the reality is that the funding tool isn't going to be on the table for the LHINs to use, but the other tools can be used effectively and we can get much better performance out of our primary care system. In doing so, we'll have much better performance of the entire health care system.

M^{me} France Gélinas: So it's not there now. If we were to change it to make it there, what would be wrong with that?

Mr. Robert Morton: I'm sorry—change?

M^{me} France Gélinas: As in, you don't fund primary care organizations or providers now. If we were to increase your mandate so that you were to fund primary care organizations and individuals, what would be wrong with that?

Mr. Robert Morton: I would say there would be nothing wrong with that. I'm just thinking about the realities of any government's ability to make that very significant shift from the historic way in which we funded. If it happened, great; but if it doesn't happen, I think we have to work with what we can do. We already do fund community health centres; they're part of the primary care system.

M^{me} France Gélinas: But what's the difference between a community health centre and an Aboriginal Health Access Centre? What's the difference between a community-led nurse practitioner clinic? Am I missing something here?

Mr. Robert Morton: Those that are outside of the OHIP envelope—and I don't pretend to understand the nature of the agreement between physicians and the province of Ontario. Any of those programs—in North Simcoe Muskoka LHIN, when we're talking about primary care, they're all there. They're at the table; they're working; they're building their relationships with

the FHTs, the family health teams, and the health links. We're very pleased. We're one of the first LHINs to have our entire geography covered by health links, and so the models are emerging.

Here is a little story about an aboriginal health centre in Wahta, a First Nations community. I was visiting them, talking with the nurse practitioner, asking about the patients that she serves. She said, "Some 22% of my patients live on reserve." So I said, "Okay, so 78% of your patients are off-reserve First Nations people." She said, "No, 72% of my patients live off reserve." They serve the broader community along the 400 corridor. She knows that her work has to be with the mainstream. We can't silo the aboriginals and First Nations people with a parallel health system.

M^{me} France Gélinas: Unfortunately, Chair, I see that my turn is up to go talk to this motion. Can we save our time? Cindy, are you ready for more questions? Or can I save the time for the next round after the Liberals?

The Vice-Chair (Mr. Ted Chudleigh): Sure.

M^{me} France Gélinas: Yes?

The Vice-Chair (Mr. Ted Chudleigh): There seems to be some agreement.

M^{me} France Gélinas: Okay. I'm running up there and I will run right back. Sorry.

The Vice-Chair (Mr. Ted Chudleigh): Shall we move to the government side?

M^{me} France Gélinas: Yes.

The Vice-Chair (Mr. Ted Chudleigh): Very good.

M^{me} France Gélinas: Sorry.

Mr. Robert Morton: Thank you for your questions.

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The Vice-Chair (Mr. Ted Chudleigh): Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair. Mr. Morton, thank you for being here. You've given us little hints about your background. Could you just explain your experience within the health care system prior to becoming the chair of the North Simcoe Muskoka LHIN?

Mr. Robert Morton: Thank you. For my first job in health care, I was hired as the personnel manager at what was to become Huronia District Hospital in Midland. I then left being a little fish in a big pond to become a big fish in a little pond, and I moved to the Georgian Manor home for the aged in Penetanguishene, where I spent a number of years.

During that time, I had some phenomenal experiences. I did a year-and-a-half—almost two-year—secondment to the then-Ministry of Community and Social Services and the Ministry of Health, as we were bringing services for seniors together under the umbrella of long-term-care reform—the beginnings of the long-term-care system and the enhancement of the community care system.

During that time, I chaired the Simcoe County District Health Council. I was also fortunate to be chair of OANHSS, the provincial organization representing not-for-profit homes for seniors. In 1997, after 18 years at the county, I was chosen to lead the establishment of the community care access centre in Simcoe county. I spent a

number of years there, and was chair of the Ontario Association of Community Care Access Centres.

There was a shuffle within the CCACs around 2001, and I was asked to take on the responsibilities at Peel's CCAC, so moving from a medium-sized CCAC to one of the largest CCACs in the province. I was there at the time that the LHINs were being planned and ready to be implemented, and I was of an age thinking that that's going to be for some younger people and that I was going to finish my career there. But I was approached by the Children's Treatment Network of Simcoe York, an example that I gave earlier, and I was asked to become the founding CEO of that. That was a phenomenal journey for me and for our communities, as we really made a difference in the lives of kids with multiple disabilities. That program was recognized with a couple of national awards for pediatric home care innovation and with an innovation award from IPAC/Deloitte.

I reached the end of the time that I thought I wanted to work, and just at that time, my local hospital was in trouble. Huronia District Hospital, in partnership with Penetanguishene General Hospital, were under supervision because the community had come to disagree with positions that the board was preparing to take. So the board resigned and a supervisor was appointed. After his work and recommendations, a new board was selected, and I was chosen to chair the newly-merged Midland and Penetanguishene hospitals, which have since become Georgian Bay General Hospital. That was a very unique experience, and during that time I did a number of consulting contracts with Deloitte, KPMG and some other firms.

As my tenure as chair at GBGH was coming to an end, I was approached to move to the LHIN. For me, going to the LHIN was an opportunity to bring the significant learnings I'd had in all of my work, in particular at the Children's Treatment Network: that you can create an integrated system not by merging organizations or forcing marriages; if you really focus on who you're serving, you can do incredible things and you can end up creating an integrated system.

If you give the power to front-line workers and give them the tools to redesign how work is done, you'll come up with better examples. As I said in my presentation, that's exactly what we're doing in north Simcoe, within organizations and across organizations, as we try to redesign our system.

Ms. Helena Jaczek: Thank you. So you obviously had experience with the previous system of regional offices of the ministry—both the Ministry of Health and ComSoc—as well as district health councils. Now, obviously, as LHIN chair, you're seeing the new way of managing health care providers in the community. So can you tell us what exactly is the difference? I think I've heard, through what we've heard already, that you like the new system, so can you really encapsulate for us just what the advantage of having LHINs versus the previous organization actually is?

Mr. Robert Morton: The LHINs have the ability—I wouldn't use the word "power," but the ability—to

facilitate collaborative work amongst providers. They do have the power, but I don't believe that using it as power gets you where you want to go. You can't force people to work together; you have to lay the foundation for people to be able to focus on who they're serving and to find a better way. So that's the unique role that LHINs play, that they have this—yes, they're managing accountabilities and they are holding people accountable to their HSAA, making sure that they balance their budget, but once that is in place, then it's about improving the system. As I say, when I talk to health service provider boards, I say, "The LHIN's goal here is to make you as successful as you possibly can be, and you'll get there with robust collaborative partnerships, getting together with your partner organizations at the board level, at the leadership level and at the front-line level to find new ways, better ways, of serving the vulnerable people in our community."

Ms. Helena Jaczek: I was obviously interested in your reference to the Children's Treatment Network of Simcoe York. I'm very familiar with that organization, and the office piece is in my riding. But what role did the LHIN play? I was very much under the impression that there were a lot of service providers very concerned about care of children with developmental disabilities and that they came together voluntarily, in essence, and created what we see now. Can you again just sort of outline why we need a LHIN for that to happen?

Mr. Robert Morton: Well, just a little bit about that context. The envelope of funding for children's treatment centres: Even though the roots of it are under the Public Hospitals Act, the administration of those fundings fell under the Ministry of Children and Youth Services. But the reality is that kids looking to the MCYS for service are the same kids who are looking to the health system, the education system, the child protection system—you know, the whole system. So the model there said, "It doesn't matter who the front-line worker works for; these kids need help across the continuum, so let's make it possible for these kids"—and this isn't about serving every kid. There are thousands in York, in Simcoe, who are—the south end of Simcoe are particularly young compared to the rest of the province. But this is about 4,800 kids in those two jurisdictions with multiple disabilities. It wasn't trying to fix the system for every kid; it was just trying to fix the system for kids with high needs, just like at this stage with health links we're not trying to fix the system for everybody; we're focusing on those most in need of the system and giving the tools to make that happen.

So while some of our partners were funded by LHINs—the CCAC piece, the hospital piece—the majority of partners were outside of that envelope, were MCYS- or MCSS-funded, or Ministry of Education. So we needed to go beyond that, but there was much that we learned that has been very helpful to the rest of the system.

For example, when we started Children's Treatment Network, we said, "We don't want a back office." Yes,

you need to pay the small number of people who work for you when you need to do your submissions to the ministry. “Who can we contract with for that?” So we actually went to the Simcoe CCAC at the time, now North Simcoe Muskoka CCAC, because they were in an initiative of saying to all of the community support agencies, including the community health centres, “We’ll come together and we’ll create a back office for all of us.”

Now that back-office integration—15 or maybe 18 organizations, all of their reporting, recording, payroll and finance—is done in a centralized office at much lower cost and with much higher quality than could ever have been done, had each of those agencies had their own—

Ms. Helena Jaczek: I understand, but you haven’t mentioned the word “LHIN”—

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Mr. Robert Morton: Okay. That was work that we did with the LHIN to support that. We became the poster child for back-office integration for the LHIN.

In Central LHIN—in order to share information on the single plan of care, you have to deal with several pieces of privacy legislation, including the Municipal Act, the Education Act, and the privacy act, of course. All of the work that we did was very appropriate, and the Central LHIN used those tools, that suite of work, to help build their palliative care network. It’s exactly the same thing: a very high-needs group of people, people who are at the end stage of their life.

While Children’s Treatment Network isn’t a funded HSP, it’s very much a part of—when we look at our work at a LHIN, if you are only focusing on your HSPs, not enough people are at the table. I talked about our consultation: 20,000 hours, 5,000 people and 160 organizations. Only 75 or 76 of them are HSPs. The system is much bigger.

If we’re dealing with children’s mental health, and you have to, particularly around the transition age, where you move from—if you’re hospitalized as a kid for a mental health issue, that involves the hospital system, it usually involves the school system, and it may involve the home system. But when we do the transition, then all of your mental health needs need to be met by the health care system. An effective LHIN recognizes that the partners are much broader than just the funded HSPs.

Again, using the North Simcoe Muskoka example—and this would be repeated time and time again in other LHINs, some to a greater extent, and perhaps some to a lesser extent—you can’t do it if public health isn’t at the table. They’re the partners on the integrated falls program. You can’t do it without EMS at the table, so that involves the municipalities, because you’re doing urgent transfers and you’re doing non-urgent transfers. That can be a horrendous bottleneck within the system. You can’t improve ER wait times unless you’re involving EMS with that discussion.

Ms. Helena Jaczek: So at the end of the day, you’re saying LHINs are providing a vital function in the facilitation of integration, and kind of being a driving force to make it happen.

Mr. Robert Morton: Yes, and holding the system accountable to work within the funds that they have, to drive better value for money.

Ms. Helena Jaczek: Mr. Morton, you’re here today, though, because you are co-chair of this leadership council. This is where the 14 chairs and the 14 CEOs come together. Do you elect your co-chairs? Or do you—

Mr. Robert Morton: I’m trying to think how I got this job. It must have been a short straw.

Ms. Helena Jaczek: For how long are you co-chair of this leadership council?

Mr. Robert Morton: It’s a two-year period. One year, you support the other chair. I’m in my second year, so I’m the big chair or, I guess, the major spokesperson. This term will end at the end of the fiscal period.

Ms. Helena Jaczek: This leadership council is made up of board members?

Mr. Robert Morton: It’s the 14 LHIN chairs and the 14 CEOs. The CEOs meet on a more regular basis. We meet four times a year. We’re trying to do three times a year face to face, and one by video teleconference. In the off months, we’ll do a teleconference call. We’re exploring ways in which we can use webinars and other technology to improve the communication between and amongst us.

We’re recognizing that we have a lot to learn from each other. At the last chairs’ council meeting, we invited two chairs—and we’ll continue to do it—to do a best-practice case study on what’s happening in your LHIN and what we can learn from that—good-news stories or bad-news stories. That’s how we’re using that structure to help advance the agenda.

The leadership council and chairs’ council don’t exist between the LHINs and the minister. The accountability is between the LHIN boards and their chairs to the minister. The leadership council and chairs council are mechanisms that we’ve agreed upon to help us do our work, but we’re not like a provincial association that’s sort of in between.

Ms. Helena Jaczek: Right. I was pleased to receive from my board chair of the Central LHIN, John Langs, some 17 recommendations in terms of this LHSIA review, making very precise—he is a lawyer—recommendations in terms of looking at the legislation and certain areas where, in the Central LHIN’s view, there might be some need for change. Is your leadership council coordinating suggestions coming in and will we be the recipient of the combined wisdom, the integrated wisdom of the 14 LHINs?

Mr. Robert Morton: Yes. The timing of today meant that we didn’t have—even though we knew it was coming, we didn’t know when the timing was. We knew we needed to come at the first day to speak as broadly as we could. So my goal was to introduce a range of themes that will be picked up on by my colleagues. We’ll be working with the questions you’ve asked today where I’ve not been able to provide fulsome answers. We’ll make sure that as further presentations, both verbal and written, are made, we’ll pick up on the gaps that I have in my knowledge and understanding.

Ms. Helena Jaczek: I think it would be very useful for all of us to have certainly the combined wisdom from the field, from the LHINs themselves. Of course, we're going to be listening to many other associations and stakeholders as well—and we certainly asked the deputy last week in terms of the ministry's thinking after many years now, because, as has been said many times, with regionalization across the country there has been several iterations; there have been changes over time. We may not have got it absolutely right the first time, but we would welcome that input. So we would be very interested in receiving that in as timely a fashion as you can provide it.

Turning to an area that my colleague Ms. Gélinas came up with: boundaries—certainly from health service providers, those who have accountability agreements with the Central LHIN, it has come to my attention that they are not happy about the boundaries, especially in the GTA. We heard last week from our colleague Ms. Cansfield, whose riding actually has four different LHINs that serve her community. The difference in terms of the service provided is very readily apparent. This is something that I believe we will be hearing from health service providers in terms of boundaries.

From your perspective, this isn't something that has come up in your leadership council discussions?

Mr. Robert Morton: The only extent to which we've discussed it as leads were, we're working with the structure that was given to us. We're doing everything we can to make it work as effectively as possible. We recognize that LHIN boundaries are not meant to be boundaries for individuals in how they receive service, but we do recognize that for some of our health service providers it means they're dealing with multiple LHINs.

I think of the country of Simcoe. Three of their long-term-care facilities are in North Simcoe Muskoka; one is in Central. The Parry Sound-Muskoka mental health agency has offices in Parry Sound as well as Huntsville. So they're between North East and North Simcoe-Muskoka.

As we look at a comprehensive review of the legislation, it may be something that needs to be addressed, but I don't find it a burning platform at this stage. There are other things that could be dealt with in the short term with a potential longer-term look at that as a piece of it. However, I'm really pleased that you're in a position to hear from the health service providers, particularly those who are challenged by working with more than one LHIN. From a patient perspective, however, it shouldn't matter where they live what LHIN they're receiving service from.

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Ms. Helena Jaczek: Well, it does impact considerably, certainly on my constituents, and I hear from them all the time.

You said this is not a burning issue for you. Are there any burning issues for you?

Mr. Robert Morton: I'll come back to primary care and how health links are going to evolve. It's very

exciting. There are some columnists and bloggers I read who say, "In this kind of change, we can expect only 20% of them to succeed." We can't have that kind of success rate on change. We need 100% success in that. So the burning platform for me would be to design accountability mechanisms within the legislation that allow us to support and help the growth and development of health links. As it is now—and I go back to the other member's comments about funding—I'm not expecting significant change in the funding model. Health links that are sponsored by a family health team are directly funded. For health links that are led by a community health centre, the funding flows through the LHIN. It doesn't really matter. It's public money, and we need to hold them accountable to their business plans and for the targets that they're approaching. So it's those tools to hold the collaborative health links accountable that are really important.

Ms. Helena Jaczek: We asked the deputy last week if there were any other areas, from the ministry's perspective, that they were looking at including in the responsibilities of the LHINs, and I think the legal counsel mentioned independent health facilities. Do you see any other areas that you would like to see included within the responsibilities of the LHINs?

Mr. Robert Morton: As we move to a more population-based agenda, as we look at not just the repair shop part of the health care system, as we look at injury prevention, as we look at disease prevention, health promotion, that continuum has to be connected to the health care system. That would suggest that when we look at how public health is organized, that's another area that—again, I wouldn't say this is a burning platform, because in many places, locally, our medical officer of health is actively involved in the LHINs' change processes. He and the board of health—we have this mechanism called the governance coordinating council that's giving advice to all of our governing bodies as we establish the right way to govern integrated initiatives, the programs that cross organizations. One of the very active members of that is the vice-chair of the board of health, so he comes wearing a different hat, but he's part of the governance picture. So they don't have to be there.

I wouldn't try to answer the question, "Are public health units accountable?" I don't know the mechanisms that are in place, but I know that they're a very critically important part of the health care system.

Ms. Helena Jaczek: And of course, their boundaries are completely different—

Mr. Robert Morton: And their boundaries are different, as well.

Ms. Helena Jaczek: And there is municipal money in public health.

Mr. Robert Morton: Yes.

Ms. Helena Jaczek: So that would, I suggest, be an incredible difficulty.

Mr. Robert Morton: So let's keep them at the table and let's not necessarily get too excited about where their funding comes from.

Ms. Helena Jaczek: In terms of bringing people to the table, you've talked quite a bit about primary care, and I guess the first crack is through health links. But you do have something called a Health Professionals Advisory Committee. I believe we heard, legislatively, there is a provision that each LHIN establish that group. Do you find that a useful group?

Mr. Robert Morton: Not particularly. I can understand why it was included in the legislation at the beginning, because we didn't know where we were going. We had this grand view that we needed to engage communities more in discussions about change; we needed to change how service providers worked. So it was all about change going in. And so there was significant push-back from a number of provider organizations and some of the professional organizations as well. So as an attempt to bring them forward, the professional advisory councils were established as a way to engage them.

As time has unfolded, the need for that in—certainly in North Simcoe Muskoka, we don't need that anymore. There's confidence and comfort that professional interests are dealt with in a most comprehensive way, and to continue to have it would be to create another silo that we don't need.

Ms. Helena Jaczek: Okay. I have five more minutes, Chair?

The Vice-Chair (Mr. Ted Chudleigh): Yes, just under.

Ms. Helena Jaczek: Okay. Service accountability agreements: In terms of funding, I understand that sometimes the health service provider delays in signing the service accountability agreement, and yet funds continue to flow, because there might be a difficulty in providing an alternate health service provider. What do you see? Is there some need for clarity or some change legislatively there?

Mr. Robert Morton: I'm thinking of the nice way to say this, but perhaps I'll just be bold. We all play games. There's gaming within the system about whether you sign or not. But clearly, the mechanisms within an SAA, a service accountability agreement, talk to it having an evergreen facility to it. And so it's the re-signing of the agreement that connects in any new funding.

So base funding will continue, because you can't just say to a hospital that has said, "We can't sign the HSAA because we don't know what our funding will be through the new funding model, HBAM, or we don't know what the prices on the quality-based procedures are"—it would be like cutting off your nose to spite your face if you said, "Okay. Since we don't have an HSAA signed for you as of the beginning of the period, we're cutting all of your money off." We will not add any additional funding, any changed funding, until the HSAA is added, but it would just create chaos within the system if we didn't continue to flow money. But I'm suggesting—my understanding of the HSAA is it allows us to keep funding at the previous year's rate until the new SAA is executed.

Ms. Helena Jaczek: We'll keep whatever we have—a minute or two—for the next round.

The Vice-Chair (Mr. Ted Chudleigh): Thank you. You have two minutes and 40 seconds, I believe.

Mrs. Christine Elliott: Okay. I'll try to use it wisely.

Thank you very much, Mr. Morton, for your presentation. In speaking about some of the challenges to the LHINs, we've talked a lot about primary care. We have talked a little bit about children's treatment centres and the fact that they're not included. I was just wondering if you could comment on any concerns that you have around that and any ways that you see it could be dealt with. I recognize they're funded by different ministries, but we're seeing more collaboration amongst ministries on various different services and issues. I would just like your comments on children's services generally, if you would.

Mr. Robert Morton: Children's services generally—it's tough. If you're a parent of a kid with significant disabilities, it's really tough. You're looking to a whole range of segments, sectors and silos within the system, and when parents say to me, "I tell my story again and again and again. Don't you people talk to each other?" or "I carry a file box with me to meetings," it shows the need for us to find ways of serving kids' needs.

So there are many players in the kids' space. There's the Ministry of Children and Youth Services for children's mental health. There's the children's treatment centres for rehab services, for the preschool speech and language program, for the early identification program, so moving into the developmental services space. Then we start to connect to the Ministry of Community and Social Services for these kids, as well, as they become adults and certain programs are delivered by the local association for community living or however it's named within their community.

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Then we have health, and health is there for those kids from the moment they're born, through their primary care—through family physicians to specialty services, pediatricians and specialty hospitals. An emergency visit connects those kids to the system as well. We're all in it with these kids, be they kids who are just having an acute episode or kids who have a chronic disability or a condition that requires ongoing care.

Generally, there are real challenges, and some very good work has been done. In the complex care coordination work that was done by Dr. Charlotte Moore, she focused in three spaces. One is kids who are medically fragile and technologically dependent, and there are some good recommendations for systems integration. We're never going to put the whole—we're not going to mush everything together. We've got to find workarounds for these kids.

The Vice-Chair (Mr. Ted Chudleigh): Thank you, Dr. Morton. Our time is up. We'll move to the NDP.

Miss Monique Taylor: That will be me, Chair. How long do I have, Chair, like, total?

The Vice-Chair (Mr. Ted Chudleigh): Ten minutes.

Miss Monique Taylor: We have 10 minutes left? Great. Okay, thanks.

Hi. Thanks for being here.

Mr. Robert Morton: Hi.

Miss Monique Taylor: My question is around long-term-care facilities. You had stated earlier that baby boomers want to stay at home. I agree with you: That's probably the case, I'm sure, in most cases. But we're finding issues where there are wait times in so many different service areas that that's becoming an impossible task.

I have a resident right now—he has Parkinson's—who has been waiting to get a specialist appointment for a year. Now that he has got the appointment, he is told it's two years until the appointment. When the family called to complain, they kind of switched it back down to a year. But at this point, the Parkinson's is completely out of control, and they're going to have no choice but to put that person in a long-term-care facility. What's your thought on that?

Mr. Robert Morton: We talked about primary care at length. A key piece, after we work through primary care, is specialized medical services.

You're absolutely right: We have incredible challenges. In some parts of the province there's a dearth of providers—

Miss Monique Taylor: I'm from Hamilton.

Mr. Robert Morton: Yes. In some parts of the province, there's a lack of providers. There are some subspecialties that are as scarce as hen's teeth. The geriatric specialists: In the whole of North Simcoe Muskoka, we have one, and numbers should show that we need many more.

What it speaks to is a different way of manpower planning. It goes back to the OHIP question; it goes back to the education question, that if we're really serious about a system, then we need to start managing health-care human resources in a more comprehensive way than just letting the alleged marketplace manage the supply side. We need to be much more thoughtful—and this is on a province-wide basis—about saying, "Where do we need certain physicians? Where do we need skills?" What's the plan? How do we work with the education system to say that in 2020, we'll need X number of additional gerontologists, rather than letting the current—

Miss Monique Taylor: But we're failing right now, and we're coming into this baby boomers crisis very quickly. I hope that you do change that scope, that people want to stay at home, because, yes, even though they do, our system as it sits right now is, unfortunately, not going to allow that, so we need to implement more beds.

I know that my city is so far behind. I have people on the wait-list who are never going to see that list because, unfortunately, they're going to die before they get there. Our CCAC is just on overload, trying to manage these. Our hospital beds are completely in wait-time crisis also. I know my colleagues still have many questions. But it's a major issue in Hamilton, where I'm coming from, and I think it's something that needs to be addressed.

Mr. Robert Morton: Yes, and in the ministry LHIN performance agreement that was signed for this year, there's a joint commitment between the LHINs and the ministry to look at this capacity question, to provide

some direction so that we identify the significant gaps—the overages, if they exist anywhere—and we end up developing a plan that says, "How are we going to move forward?" We have to do it with the recognition that different communities have to have a different response because of the other mix of providers, the geography and the socio-economics of those communities.

Ms. Cindy Forster: We only have a very short time left, so if you could make your answer to my question as brief as possible: At a high level, how is the funding doled out amongst the LHINs? I come from an area, Niagara, where we had chronic underfunding of our hospital for many, many years. We have a huge lack of mental health services. So is it based on population? Is it based on geography? How often do you actually look at the funding and move that funding perhaps between LHINs?

Mr. Robert Morton: Great questions. It's going to be hard to answer briefly. Seventy per cent of our funding is to hospitals. The hospital funding is based upon a historical way in which hospitals were funded, and there were a variety of formulas that tried to recognize growth in communities and recognize demand. We're in the midst of implementing a new mechanism for funding hospitals that moves it away from global funding. Global funding: Any increase awarded the effective hospital the same as it rewarded the ineffective hospital. So over time, as we reduce the amount of global funding, we look more at the quality-based procedures. If it's costing your hospital \$100 to do something and it's costing another hospital \$50 to do something, if we pay everybody \$60, we're going to reward the effective hospital and the ineffective hospital will have to improve. That's the quality-based procedures piece.

Then the balance of the funding is based upon the health-based allocation methodology, HBAM. That methodology looks at a population, taking it deeper than just the total number of people, but looking at it age-weighted: an older population will need more. But then it layers on that other considerations about health status. We know that lower socio-economics result in higher need for health services, so those poorer communities will end up having more through the HBAM formula. The LHINs work with the government on the implementation side, finding the corridors by which we can move forward.

On the community side—and then there's long-term care—that's where we've been trying to grow capacity in the system. The additional funding that LHINs have had available to them have gone to build community capacity, whether that's in community supports or mental health. Locally, we've done some very significant investments on the mental health side because our mental health planning work that the community is doing has pointed out a number of places where investments would really make a significant difference: some crisis intervention, some child and youth work, and some building of capacity within the organizations.

The 14% that is long-term-care facilities: That funding is tied to a funding formula that looks at the level of care

required by the individuals occupying the long-term-care facility beds. It's by—

Ms. Cindy Forster: Score.

Mr. Robert Morton: —score, methodology, and then divides up the provincial pot based upon your score relative to the provincial average. That's the big part of long-term-care facilities. That's personal care. The next part is for raw food; the next part is for—

Ms. Cindy Forster: I'm familiar with that.

Mr. Robert Morton: So all of those go together, but that—

Ms. Cindy Forster: But what about between LHINs?

Mr. Robert Morton: Between LHINs? The HBAM is driving funding out of inefficient hospitals into efficient hospitals, and that's not done on a LHIN-boundary basis because it looks at all hospitals and their performance. If we're a LHIN with hospitals that have been very effective, the hospital pot will grow, rewarding them for their efficiency and catching up on the underfunding. In other LHINs where hospitals have been relatively inefficient, that funding doesn't remain in the LHIN; it goes on a horizontal basis across the hospital silo.

Ms. Cindy Forster: Thank you.

M^{me} France Gélinas: We also have a francophone entity and a planning entity for First Nations. There are a number of francophone entities that are also not happy with their relationship with the LHINs—and I see you've put it in what you've put there: You ask the boards to align their priorities with the LHIN priorities. So what happens when the francophone entities listen to the francophone community and say, "This is the direction we want to take"? We'll take, for example, "We would like a new francophone community health centre in our community." They bring that to the LHIN board and the LHIN says, "This is not part of the LHIN priorities. Thank you for coming. Come again."

The Vice-Chair (Mr. Ted Chudleigh): In 30 seconds or less.

Mr. Robert Morton: In 30 seconds or less. I'll speak to the local experience on that very question—

M^{me} France Gélinas: I'm more interested in, do you have suggestions for improvement?

Mr. Robert Morton: Yes. I think every entity needs to have strong relationships with the LHIN. The entity needs to make deputations, delegations, part of the education program at the LHIN, so that the LHIN board members understand the role of entities and the importance of French-language services. We need to inform each other about our work. It is a partnership. We're interested in the same thing. All of the LHINs have a French-language services coordinator who should be providing advice to the board and to the providers as we, within the mix of providers, move to improving services for people—

M^{me} France Gélinas: But this is how it should work, and it is not working. I was asking for your recommendations.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Mr. Morton.

Ms. Gélinas has a very busy day, and I wonder if we could ask you, on behalf of the committee, to convey "Happy birthday" to your husband when you see him next.

Laughter.

The Vice-Chair (Mr. Ted Chudleigh): The government has two minutes left.

Ms. Helena Jaczek: Mr. Morton, just to pick up a little bit on funding: Obviously, as I represent an area within the Central LHIN, we're very interested in implementation of HBAM to address our very rapidly growing population. As part of this leadership council, do you discuss implementation of HBAM? Obviously, there are going to be winners and losers between the various LHINs. What kinds of discussions have you had?

Mr. Robert Morton: It's on the table. I wouldn't say we've had robust discussions to date, but as we see the implications of HBAM, as the so-called winners and losers become clear, we need to be very strategic. The government has done a good job with the mitigation, with the corridors, to try to ease that, but hospitals need to be working for where they're going to be over time. We've given time for hospitals to get their house in order. Hopefully, they'll be able to do that.

Ms. Helena Jaczek: What time frame are you looking at for implementation?

Mr. Robert Morton: I haven't got that technical piece. We'll make sure we get the right answer. It's either three years yet to go or—

Ms. Helena Jaczek: Well, I think it was four years originally, so—

Mr. Robert Morton: It was four years initially. Whether it's three years left or two years left—I'd have to check a calendar on that.

Ms. Helena Jaczek: Okay. I think we'll just leave it at that.

The Vice-Chair (Mr. Ted Chudleigh): Good. Thank you very much.

I believe this committee now stands adjourned until tomorrow—

M^{me} France Gélinas: No, no. We have to talk about our travelling days.

The Vice-Chair (Mr. Ted Chudleigh): I'm sorry, that's not on the agenda, and I'm not willing to entertain it. You'll have to have a subcommittee meeting to talk about it.

We stand adjourned until tomorrow after routine proceedings.

The committee adjourned at 1604.

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Standing Committee on Social Policy

Local Health System
Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur
l'intégration du système
de santé local



Chair: Ernie Hardeman
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 2 December 2013

Lundi 2 décembre 2013

*The committee met at 1420 in committee room 1.*LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Routine proceedings have finished and it's now orders of the day, so that means this committee will be called to order.

This is a meeting of the Standing Committee on Social Policy, and we're here for the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of this act.

LOCAL HEALTH
INTEGRATION NETWORK
CHIEF EXECUTIVE OFFICERS

The Chair (Mr. Ernie Hardeman): We're doing public delegations today, and the first one is the local health integration network chief executive officers, and Camille Orridge, lead chief executive officer. Welcome. Any one of the chairs at the front is fine.

Thank you very much for coming forward today. We will have up to half an hour for you to make a presentation to us this afternoon. Upon that, we will have up to half an hour for each caucus to have any questions or comments on your presentation. Hopefully, it will end up at the end that we will all benefit from your visit here this afternoon. So thank you very much for coming in, and the floor is yours.

Ms. Camille Orridge: Thank you. My name is Camille Orridge, and I'm the CEO of the Toronto Central Local Health Integration Network. I'm here today representing all 14 LHIN CEOs.

I want to start by thanking you for taking the opportunity for me to come here today. We welcome a review of the legislation that governs the LHINs, because this review allows us to strengthen the legislation and to enable the LHINs to meet our fullest potential.

I want to take the time to review the recommendations by the LHINs to this committee.

The first recommendation is to give the LHINs greater responsibility for managing the accountability for primary care and independent health facilities. While LHINs are proposing greater responsibility for planning and managing the accountability for primary care, this does not mean making changes to how physicians are

paid. The negotiation of physicians' compensation should remain the purview of the Ministry of Health and Long-Term Care and the Ontario Medical Association. Billing would continue through OHIP.

In addition, as the LHINs work with local providers in their communities as a means to improve access and quality of care, it will be important that these organizations are appropriately connected to the rest of the local health system.

The second recommendation is to take advantage of provisions already in LHSIA, regulations that were drafted but never enacted, that would benefit the system today: regulations related to planning for aboriginal communities and regulations related to the flexibility of reallocating funds in order to influence performance of health service providers or shift funding between sectors or organizations as the system evolves.

Under LHSIA, LHINs are not able to hold surplus funds. Unspent operational and transfer payment funds are returned to the ministry at the end of each fiscal year. Allowing us to retain surplus into the following fiscal year and permitting health service providers to retain a portion of their surplus would give the LHINs a greater ability to fund larger and multi-year change initiatives.

The third recommendation is to define the responsibilities of the system for health service provider boards. As independent corporate entities, many boards see their responsibilities as primarily to their organizations, and don't always see themselves as part of a system or a network of providers caring for the same population, often for the same individuals.

LHSIA created new requirements for health service provider boards that obligate them to incorporate community engagement in their strategic planning and to align their priorities to LHIN priorities.

The act also includes a role for service providers to identify and participate in health system integration initiatives. While LHINs have had considerable success in collaborative governance in some areas, maintaining a collective commitment to system goals can be a challenge.

The final recommendation is to reduce the administrative barriers to integration. Collectively and as individual LHINs, we need to focus and accelerate our integration efforts in ways that support more person-centred care, improved access and quality, and greater sustainability. With eight years of experience behind us, LHINs have

identified several areas where integration can be administratively cumbersome for all parties involved. Through the review, the LHINs will be sharing with the standing committee our perspective on opportunities to improve the legislation.

I realize that, here today, I am speaking to a group of individuals who represent the public. As the CEO of the Toronto Central LHIN, I too am keenly aware of the responsibilities to the public to work towards improving their experience in their health care system and ultimately optimize their health care outcomes. Understanding and improving the patient experience has been the thread throughout my own career; it has continuously grounded the work that I do and has given it true meaning.

If I were to choose one single way to describe how LHINs are changing the system, I would say that it is to bring the patient perspective into planning. It is to ask how health care should be experienced before, during and after it is delivered for a patient in our communities.

LHINs are privileged to have community and patient engagement written within our mandate, for it shapes and drives everything that we do. The LHSIA legislation sets the architecture for a patient-centred system. The legislation sends a powerful message—that patients and communities should be front and centre in health care design and delivery, not individual providers—but it is the on-the-ground work of the LHIN that brings this to life.

Governments have a bird's-eye view of the system, and that's appropriate; they fly at 30,000 feet and establish in broad strokes what the public should be able to expect from our universal health care system across the province. Providers operate at the street level, with a strong understanding of the individuals who come through their doors.

No one else is tasked with looking at the system in the way that we are: to consider what health care looks like from the perspective of the patient. The LHIN is here to think about and plan for how our patients move across and through the system. It is our job not to help navigate patients through a tangled system, but instead to provide an invisible guide for patients by rebuilding and transforming the system into one where providers know who is doing what for patients, they communicate effectively during handoffs, and the patients themselves are empowered to own and direct their own personal health journey with the right supports in place.

The LHINs are regional planning entities. The regional planning model is pervasive across Canada and in most publicly funded health systems across the world. There is a broad recognition that a regional model is the only way to achieve provincial or national level goals in jurisdictions that have fundamentally different circumstances. No one can argue with the notion that the challenges of planning health services are different for the remote communities of the north or the agricultural communities around Leamington than they would be for downtown Toronto, where we have the highest density per square block in North America.

The regional model affords flexibility and allows for the transfer of accountability to a level that is much

closer to the front lines of health care while still maintaining strong accountability and ties to the provincial mandate. It is critically important that all Ontarians can have the expectation of equal outcomes of health care, regardless of the circumstances or where they live.

The provincial direction is set based on the government's mandate for health care across Ontario. The role of the LHINs has evolved along with changes in the provincial focus. It is not a matter of shifting goal posts, but rather a story of an evolving context, new and emerging challenges and a drive for continuous quality improvement. Health care, for me, is really based on continuous quality improvement. To give you a sense of what this has looked like, I will discuss the major areas of focus during this time, what the LHINs' role was and what the impact has been.

1430

The first four years of the LHINs were driven by a provincial thrust to improve surgical wait times. This was a key area of focus for the LHINs' work. Our role was to set service accountability agreements with the hospitals, negotiate targets, monitor change and move patients or volumes around the system to leverage and reduce wait-lists. We delivered. Ontario moved from the bottom of the pile to scoring straight As in the national scorecards. Our results in wait times have outpaced other jurisdictions in Canada.

In 2008, a decision was made to improve emergency department wait times. This work continues today, and the role of the LHINs is again to create service accountability agreements to support this focus and to monitor change. Working through the ED wait times, however, brought some important system challenges to light with respect to the need to build a strong community sector. For example, it became clear that more resources and infrastructure had to be built into the community to address the large number of people waiting in hospital beds who could and should have been discharged home had these supports been in place.

The role of the LHINs in tackling these very complex challenges has been critical. There is no other entity tasked with making sure that behavioural and, in turn, workflow changes are happening across health care organizations and across and among clinicians.

Home First is an amazing example of the leadership role that LHINs play in holding providers accountable for better patient and system outcomes. Home First is a philosophy focused on keeping patients, especially high-needs seniors, safe in their homes for as long as possible with community supports. As soon as someone enters hospital, Home First helps to ensure that adequate resources are in place to support the person to get and stay safely at home while they and their families make decisions about long-term-care options.

One reason why emergency departments get backed up is that needed beds are occupied by patients whose acute care is completed and who are waiting to be transferred to a better place of care: home, supportive housing or a long-term-care home. Home First started in the

Mississauga Halton LHIN, and today all LHINS across Ontario are doing Home First. The Health Council of Canada's 2012 report states, "The Home First philosophy is quickly becoming an important layer in the health care system of the provinces where it is applied."

With a few minutes, just to give you the results: In Mississauga Halton, there was a 45% reduction in the number of ALC patients—those are patients in hospital who were ready to leave hospital—an 85% reduction in the total number of such patients being designated from 2008 to 2013. There has also been a 45.9% decrease in the number of referrals to long-term care directly from hospitals.

Imagine the trauma of being admitted to hospital, and then being discharged from hospital to long-term care. Home First suggests that you go home, get supports at home and then transition from there to long-term care, should that be required. The success of Mississauga Halton was repeated in the Central LHIN, Toronto Central LHIN and the North West LHIN, and now it has been scaled up entirely across the country.

The Home First initiative and other efforts to ensure that patients receive care in the most appropriate place have sparked a number of related innovations across the province. For example, in my LHIN, 134 long-stay ALCs were transitioned to the right place of care. These are people who were in hospital for longer than six months, sometimes longer than a year.

While this may seem small, the impact is enormous. Transferring one such long-stay ALC patient who has been in hospital for one year makes that bed available to 10 to 40 people using that same bed. North Simcoe Muskoka supported Home First seniors with an expansion of telemedicine to monitor blood pressure and vital signs.

The ER wait times strategy also shone a light on the need to deal with patients who were coming to emergency departments because of access issues with primary care in their community or a lack of basic support services in their community. This is particularly true for complex patients who have high needs. It is true across the province, but I will speak of a few examples. I'll use some from my own LHIN.

Before, an individual with mental health issues had to apply to 28 mental health supportive housing organizations, completing all the different forms to be placed on each wait-list for housing. Clients were on a number of different wait-lists. Now, there is one application and one list, streamlining access to over 4,500 supportive housing units in Toronto. Clients are now placed on a common wait-list for all suitable units, and caseworkers support clients through the intake process and to ensure that they have the support they need. This coordinated access initiative has expanded to now include streamlined access to case management and assertive community treatment teams. Efforts are now under way to include streamlined access to addiction services.

Before, for a family physician with a family in his office who had identified that their senior parent was in

need of social and personal support services, the physician or the family had to contact up to 30 different agencies regarding 25 different support services for seniors. Now, through the Community Navigation and Access Program, in collaboration with the CCACs, they have one call to make, and they are assisted in getting the right provider. There is now one integrated access point for services ranging from adult day programs, Meals on Wheels and transportation to appointments.

One last example: There are many languages spoken in the province. In Toronto, there are 170 languages. The ability to effectively communicate with a provider is critical in getting an appropriate diagnosis, understanding your treatment and managing care supports like medication and self-care. Recognizing the importance of being able to communicate with your provider in your first language, we at the Toronto Central LHIN brought all providers together to initiate one competitive procurement process for translation services that everyone could access.

Before this initiative, some hospitals and very few community agencies had a means of speaking to their patients to ensure understanding of the diagnosis, treatment, medication etc. The cost per minute ranged from \$1.80 to \$8, with most providers not being able to access or afford telephone translation.

Having brought the group together and brought the continuum together, we have now reduced the cost to \$1.50 per minute, and going down as others join. The result is improving client care, client experience, provider satisfaction and cost. In the first year, services have been translated into 89 languages, and almost 50,000 minutes of language translation have occurred. This was just the first year in this program.

These are changes that focus on removing the spaces or gaps that exist between providers, the links and the connectors that patients rely on when getting access to the providers and the care they need. Patients with multiple chronic diseases often present in the emergency department because they are challenged accessing the supports they need. We see similar patterns with patients returning to the emergency department post-discharge. Wraparound care for these patients and families, particularly the top users, has emerged as the new strategic focus for the health care system and the driving force behind system transformation.

1440

Across the province, there are approximately 1,400 health service providers, of which 154 are hospitals. The rest are community agencies or long-term-care providers.

Our system evolved in the 1950s, when we were younger, healthier communities. Now we have an aging population with a lot of chronic diseases and a lot of chronic illnesses. We need, then, to transform our system. The need for community care, given this, is on the rise, as we work to support healthy aging.

We will always need a strong hospital sector, and we are fortunate to have some of the best hospitals in the country.

Meeting the challenge of building and strengthening the community sector is one that holds many solutions for better quality, greater sustainability and a better patient experience—and, ironically, better hospital care.

The LHINs are local enough to know the context and the providers and regional enough to partner, as necessary, beyond artificial LHIN boundaries.

The LHINs are neutral; they are not entrenched with particular providers or attached to the current model.

The LHINs look at whole populations, covering broad geographies. We look not only at those who are actually accessing care, but those who should be accessing care and who will need to access care.

The LHINs integrate services. We span across the silos of providers to make sure that care is coordinated for our patients.

The LHINs have the mandate to listen to patients and communities. It is embedded in our DNA, and it is part of the reason we were established.

There is no single metric that captures the strategic objective of improving the management of complex patients. This work is critical to transform the system, and we are up to it. Managing complex patients, as I mentioned before, is the next system challenge. It involves coordinating care across all the environments. One of the ways in which we are now moving in that direction is with the advent of health links. Health links is population-based, it's local and it's getting us there.

We have worked with our partners in social services and housing to increase the value and impact of our investments, and have found that when we plan together, we do better in meeting the needs of our patients.

One thing I'd also like to bring forward is that the LHINs have in place over 1,400 service accountability agreements, and all of these have to be negotiated, brokered, mitigated and monitored. The management of these service accountability agreements is our tool that we use to improve the system.

In an environment where we have seen health care costs decrease from 6% to 2%, the LHINs have successfully been able to work with providers to maintain service. We no longer have a lot of hospitals in deficit budgets, as we go forward. Actually, the Fraser Institute, in their 2013 report, showed that Ontario is second in Canada in terms of overall value and value for money when it comes to health care spending.

Every day, LHINs work with providers to manage service pressures. As regional planners, we carry out this accountability for planning and performance management, and we do so better, I think, than any other iteration of regional entities that pre-existed.

We are transforming the system one day at a time. It's like fixing a bridge while people are still using it. You have to maintain it—while we are also looking at continuous quality improvement in other areas.

I want to thank you again for the opportunity to come and make this presentation on behalf of the LHINs, and now I would welcome your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for your very thorough presentation.

As the committee may have noticed, the bells are ringing, so we have about 20 minutes prior to having to go up to vote. So we'll start with the questioning and use as much time to our advantage as we can. We're starting with the official opposition.

Mrs. Jane McKenna: Thank you so much for coming in with this presentation. I think my first question is, at the very beginning of your introduction, you say you have orders to strengthen it and to enable the LHINs to meet their fullest potential. What do you mean by that? What fullest potential are you looking for, and in what way?

Ms. Camille Orridge: The first recommendation, that primary care is a lynchpin to providing care, particularly to frail seniors or people with complex conditions—currently, primary care is outside of the system and not integrated in our service delivery. By having the accountability agreement with primary care providers, where they work in teams and they can be integrated with other providers, we can then deliver wraparound care for those most in need.

Mrs. Jane McKenna: And how are you going to achieve that? What exactly, strategically, do you have in place to get the primary care where you need it to go?

Ms. Camille Orridge: We do that now by some primary care voluntarily working with us, and health links. For the health links, we have primary care at the table, acute care, CCACs, all of that at the table, and everybody is working together around how we coordinate care. When you can go to the table and hold everybody accountable for a particular outcome—we don't have that authority to hold primary care accountable, to participate and to achieve the common outcome.

Mrs. Jane McKenna: So how do you define “accountability”? It's mentioned so many times in here, the word “accountability,” but I sometimes just wonder if that word is just a word that we use. Just for that example of what you just said, what do you specifically mean when you say you hold them accountable for what they're bringing? What does that mean?

Ms. Camille Orridge: I'll give you a concrete example. We have an accountability agreement with the hospitals and with the CCAC. We brought them together and said, “We need to reduce the number of people in hospitals inappropriately so by this number. Now, let's figure this out.” Because we have an accountability agreement, we could write in the agreement, “For the funds you have received, these are the deliverables we expect for the population.” So they sit together with the LHINs and they then go through—they change their processes. But because it says that you need to achieve this for the dollars you get, there's a different motivation to arrive at that.

Mrs. Jane McKenna: So each one of you—this is a direct question to you. So there are 14 LHINs.

Ms. Camille Orridge: Yes.

Mrs. Jane McKenna: Do you feel that they communicate to one another? Let's say one is stronger in one area than another: Do you feel that they communicate that information for their performance targets?

Ms. Camille Orridge: I think so. Now, all 14 have performance targets. We meet with the ministry at the beginning of the year. We negotiate the targets. The targets are different for different areas, because we're all starting at different places, and then we move towards achieving the target. What's interesting is that even when you achieve the target the next year, because it's continuous improvement, you still want to improve that target. So each LHIN is working with their providers from where they started and moving that agenda.

So I would say yes, each LHIN is moving their performance agenda. We may look different just because we start at different places and have different resources, but we're all involved in continually improving the system for people who live in our communities.

Mrs. Jane McKenna: Being not service providers but system managers, what do you think their best in the last—I'm going to say eight years, as you're saying here. What do you think they've done that is great for the taxpayer that has solidified the system in a better way so that we're moving forward with the patient-centred—

Ms. Camille Orridge: The heavy emphasis on patient engagement, patient experience, looking at the metrics such as the readmission rates, the ALC days: All of those are indicators that we use to bring providers together and to look at whether we are continually improving the system for our residents. I think the LHINs have systematically done that. If we look at wait times, we have seen a decrease there. We have seen a decrease in ALC.

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I can give you an example in my own LHIN where we got our stroke scorecard and it was not what we thought was the best. So we, as a LHIN, brought the acute, the rehab and the complex all together and said, "What are we going to do to improve this? Because we've got to do this for the patients." The emergency and the ambulance were there and we fostered that dialogue. It took us about six months. At the end of that process, we had two hospitals voluntarily no longer admitting strokes, because they didn't have the numbers to have an appropriate stroke unit. We saw an expansion in the other stroke unit so that they could then provide better stroke care. They enhanced rehab and we now see dollars moving to the rehab hospitals, because we all know that within seven days you should go, post-stroke, to rehab. That's the kind of work that I would say—across the province, each LHIN may have tackled something different, but step by step, that's the kind of work we're doing to improve patient care.

Mrs. Jane McKenna: To me, the measure of your success should be through the patient, right? Because it's patient-centred.

Ms. Camille Orridge: Yes.

Mrs. Jane McKenna: So where are those measured outcomes from? As an MPP, in my office—and I'll only speak for myself. The system is fragmented. The people are struggling like crazy to get the information that they have. How it's written in here makes it sound like it's a seamless system and that there aren't any problems at all,

and I can tell you, from my office, day in and day out, that we have nothing but complaints about how it's a fragmented system.

So I guess my number one question is, if you're measuring your success through the patient, where is that so we can actually see that? Because it's not coming through my office in Burlington.

Ms. Camille Orridge: Two things I would say are: In a system that has over a million people going through it each day, I do agree and will embrace that, yes, there are areas for improvement—absolutely no question about it. We do not yet have one single measure that we can turn to for patient experience. We are now in the process of doing that. We have information like patient satisfaction surveys. We do not yet have a common set of questions across the entire system that everybody asks. We, as the LHIN, are now working with the providers to say, "We now need to work on that together so we can get at one measure that we can all report on consistently."

Mrs. Jane McKenna: Okay. It's eight years. Don't you think that would have come back eight years ago and that would have been your main target and your main goal? I'm kind of curious as to why it's taken eight years to come up with that conclusion.

Ms. Camille Orridge: I would say, yes, LHINs have been—the legislation was passed eight years ago. I would hold us more accountable in the last four years to get to this measure.

What we've done so far is looked at comparative data. We have started to have the data sources from which to gather the information, so we're looking at ICES data neighbourhood by neighbourhood. We're looking at the Picker, which is a common client satisfaction survey that everybody is using. What I would say to you is that the work has started, but it will take another year before we have that measure that everybody can rely on, because we've got to get everybody in the system asking the same question across the system.

If you were to ask each person about their individual hospital, you'd get one answer. But that's not the question we want answered about experience. We want to know about the experience across the entire system, so that's now being lined up across the system.

Mrs. Jane McKenna: I know you say there are 14 LHINs and some are urban and some are rural, but the reality is—I gather that there are different systems in each area. But if I'm a patient, I just want to know, going through the system, that the improvements you're saying you've made as system manager work or don't work. It's very simple. It's not a complicated end result.

Why is it that it's taken so long to get to that end goal? I'm just confused as to why you say that it's the last four years that you've noticed that you've been accountable, but what happened to the four years prior to that? And why is it going to take another year to figure that out? I guess if you're all supposed to be working for the best person, which is the patient, what is taking so long to actually get the proper formula? I just find it totally confusing, if you measure your success by the patient.

Ms. Camille Orridge: Yes, I'm not quite sure how I can answer that question by one simple answer, because health care is complex. The first four years, LHINs were a new organization starting up. As I said, the first was focused on wait times. Those were the priorities.

The patient experience is key. We are now trying to do the measures to do that. We have over 2,000 organizations. We're now trying to make sure that we standardize even the definitions that everybody is using about what you're asking about, about the patient experience. If we were to go today and ask everybody and every patient what does that mean, we would get a different interpretation.

So I totally agree with you—we agree with you—but the work is on the way to do that. I'm sorry, but it's not work that can be done overnight. The definitions are now being done.

I'll give you an example, again, in my LHIN. We have had all the sectors who have come together and have identified the patient experience as their number one priority. They have collectively identified what it is we're going to measure in order to do that. Each sector is beginning to gather that data.

Mrs. Jane McKenna: But you only have one measurement: the patient. This is why it seems very complex and convoluted when we talk about anything else. You only have one measurement, and that's the patient.

I guess my other thing is, for three months, most people in any employment, their probation is three months. You're in eight years. At what point do we realize that maybe it's not the best dollar for the taxpayer if we're still eight years later trying to figure out—and you're just saying that it's going to take another year to get where you need to go to measure the success of the patient. I'm confused.

Ms. Camille Orridge: Yes, and I'm sorry; I'm not sure of the question either. So let me just start. When you're talking about the patient and what the patient needs, the patient needs access—that's one of those measures that the patients have identified that's important. All across the province we have improved access. We have improved access to primary care. We have improved access to emergency departments. We have improved access to home care. So all of those are improvements in measures that the patients have received.

Mrs. Jane McKenna: But where do you get that—I'm just curious, because it's not in Burlington. So I'm trying to figure out where you are getting that data from that you're able to say those three things about access or accessibility. I don't know where you're getting that from. If you don't have surveys out there that are giving you this information, where are you getting that information from?

Ms. Camille Orridge: Where we have that information is the ICES data. ICES—and I can't remember exactly what ICES stands for—gathers data on every admission: the date they're admitted, how long they've waited, and they produce a lot of information, neighbourhood by neighbourhood, of the person's experience through the system.

CIHI, the Canadian information system, also produces information on patients' access to services. It tells you wait times—how long you'll wait for hip, how long you'll wait for knee, how long you'll wait for cataract. Those are all now official, established data points that provide information on access. Each LHIN produces a report card that gives this information.

I could go back, and certainly we'll have that discussion with the LHIN that Burlington sits in, but I am pretty sure that information is available, should be available, that can show how they've improved access, as one measure.

Mrs. Jane McKenna: Okay. So you can ask whoever else is asking—I know the other parties are here that are going to ask questions today. I find it hard to believe that I would be the only person that has this question that I'm asking you. We had Mrs. Cansfield here who brought this up herself, that you don't communicate with each other, that we're going to have a systemic problem anyway because the baby boomers are coming through. We clearly have issues and problems, and the thing that scares me is that if it's taken eight years to get where we are, and you're going to go another year before you can seem to iron things out—as the CEO of all 14 LHINs, I think the thing that worries me even more is that you're having a hard time, I guess, understanding what the question is.

Ms. Camille Orridge: Sorry, I'm the CEO of one LHIN.

Mrs. Jane McKenna: Oh, sorry. I apologize.

My last question will be, if you had legislation and you could change it to your wish list of what you would want to see changed, what would that be?

Ms. Camille Orridge: Going back, we would ask that the service agreements for primary care be included among the service agreements that are managed by the LHINs—for the independent health facilities, that their service agreements be managed by the LHINs, along with those of the hospitals and the community agencies etc.

We would ask that certain functions that were not enacted within the legislation happen. There's a function within the legislation for the French and the aboriginal communities; the French was enacted and the aboriginal wasn't. We're suggesting that that be done.

We're suggesting that the funds be able to be retained from one year to the next so that you can actually implement projects that cross over a year, to better improve client care.

We would be asking that all providers who get government-funded dollars not only be accountable to their individual boards, but have accountability for system planning and participating in improving the overall system.

Those are the major changes that we would ask for.

Mrs. Jane McKenna: Okay. That's it for me.

The Chair (Mr. Ernie Hardeman): Thank you. With that, we will stop there, before we start with the third party, and go to vote. We would ask if the delegation would be so kind as to wait for us to return after the vote,

and we ask the members of the committee to get back here as quickly as we can after the vote, to continue with this deputation.

The committee recessed from 1501 to 1517.

The Chair (Mr. Ernie Hardeman): Now that we have all parties represented, we'll call the committee back to order. We will start with the questions and comments from the third party. Ms. Forster.

Ms. Cindy Forster: Good afternoon.

Ms. Camille Orridge: Hi.

Ms. Cindy Forster: I just want to follow up—at the end, the last question, actually, from Jane McKenna, where you talked about the things you would like to see through your recommendations under the authority of the LHIN. What would health care look like if you had primary care and the other recommendations under the umbrella of the LHIN, in your opinion?

Ms. Camille Orridge: What health care would look like is, for the most complex patients or the patients who use the highest number of services, we would have a system where we could encircle those folks—wrap-around care—get providers working together with one common accountability agreement that they all have to participate in and deliver for that patient. I think we would see improved quality of care, improved access and improved safety. I think we would even end up reducing some of our costs, because some of the costs occur because of things that happen in transitions. That's a smaller number of our folks, but they're the larger users of health care of the highest cost. By having that ability, we would see significantly different—in being able to organize care for those folks.

Ms. Cindy Forster: Have you had any discussions with the OMA with respect to having primary care, under the LHINs?

Ms. Camille Orridge: Not in terms of their accountability under the LHINs, but we have been working closely all across the province with primary care. They're active participants in health links, where we're bringing folks together locally, community by community, to do the work around these populations. So they are at the table. We have incredible primary care engagement on some of these issues going forward. Their service agreements are not currently with the LHINs, but they are at the table.

Ms. Cindy Forster: There was a question asked about targets. Your response was that there aren't any standard targets; that every LHIN is operating based on where they start the year and where they're going. But, surely, there must be some standard targets across each LHIN. There may not be standards with respect to how you're going to reach that target or the amount of time you have to reach it, but there must be standard targets at each LHIN; otherwise, how would you have any equality in access to care?

Ms. Camille Orridge: Yes. For example, provincially, we would say that the number of individuals inappropriately located in a hospital bed is a target—I can't remember exactly what it is, but let's say it's 11%. It

shouldn't be any higher than that provincially. That's what everybody is working towards. What I will say is, how you get there will vary because we're all starting at different places. In the north, I think they started at 21% of their beds occupied that way. Clearly, they're not going to reach the 10% at the same rate as Toronto, which was at 12% and is now down to 10%.

That's what I was getting at: that everybody is moving towards some of these common targets, but the rate at which you get there and the issues underlying it vary provincially. We have wait time targets for hips-knees, and I think almost everybody has reached them. We have cataract targets. But we all started at different places, so that's where you'll see the variation.

Ms. Cindy Forster: So there are standard targets, though, across each LHIN, and in addition to that, specific LHINs may have their own targets based on their geography or the people who live in their community.

Ms. Camille Orridge: Yes.

Ms. Cindy Forster: With respect to community care, is there any kind of movement or initiative in place with respect to the personal support workers and the people who are out providing primary care to the most vulnerable people in our communities, to ensure that seniors don't have a different person arriving at their door every day; to make sure that these people have full-time jobs, so that they can work full-time hours for agencies? Do you have any thoughts on how we can improve that sector? We hear about it in our offices every day. I've heard about it from my own mother, who had surgery and had six different people visit her over a period of a week or two. For the most part, what she would hear from the people coming to visit her was that they were part-time; they have to work for a number of agencies; they can't get full-time hours; they're working two or three jobs.

So I just wonder, how is the LHIN and the CCAC that respond to you dealing with that issue?

Ms. Camille Orridge: I think your question has raised two issues, and one is the continuity of care. There's also a table where the LHINs and the CCACs now work together to try to look at, "How do we work together? How do we get these benchmarks?", and continuity of care is one of the issues that's on the table.

Because my previous life was in the CCAC sector, I know that there's a lot of work under way in that sector and a lot of it is being driven by the LHINs about, how do you create teams? One of the things we have to do ourselves, as providers, and get our providers to do—but also work with the public—is that in almost every service we are providing, we should expect to get the care from a team. If you're a frail senior and you need care seven days a week, you're probably not going to get one person seven days a week, but neither should you get one person every day. I know there's work under way about creating teams of people so that the family of the patient would know who the members of their team are. I know—again, an example in downtown Toronto—because density is on our side, we have then also talked about, in certain neighbourhoods where you have a lot of high-rises,

creating a team of workers who then work for everybody in that area, so everybody gets to know who they are etc. That's the kind of work that's under way.

Job security: I think it's another issue. I don't know that I have an answer for that at this time, but I do think and would support that those are the people in the system who really need some focused attention in terms of job security, benefits and pensions.

Ms. Cindy Forster: Thank you.

M^{me} France Gélinas: My question also has to do with primary care. You open up your talk by saying, "The first recommendation is to give the LHINs greater responsibility for managing the accountability for primary care and independent health facilities." I will focus on primary care. You go on to say that "this doesn't mean making changes to how physicians are paid."

LHINs have supported making changes to how every other partner that has accountability agreements with you is paid. Hospitals used to have a global budget. They now pay for procedures; they're now on their HBAM. Why would you make a statement within the first five seconds of being here that says, "But we're not going to look at that"?

Ms. Camille Orridge: Yes, it is true that LHINs enforcing and working through the accountability agreements have gone to things like quality-based procedures. But in doing that, we have not engaged in the income or the cost paid for the nurse, the doctor—any of those individually. Those negotiations take place by different bargaining units, whether it be the OMA, the OHA, SEIU. The LHIN has not stepped into that river. We focus on the service outcome for patients.

The point I was trying to make here is that we would like the primary care physicians to be accountable to deliver care. Where the negotiations take place is not 14 times by each LHIN. It's done centrally, the way it's done now, through the OMA. That's what we were trying to articulate there. We want the accountability for the contracts, to include them in that planning, but not the actual negotiations.

M^{me} France Gélinas: But you realize that that's not what you said. Your opening comment doesn't say this. Your opening comment says that "this doesn't mean making changes to how physicians are paid." That doesn't mean we're going to stay out of union negotiations. You say "this doesn't mean making changes to how physicians are paid."

Right now, you fund community health centres. Are you looking at also funding aboriginal health access centres, community-based family health teams, all family health teams, family health networks, nurse practitioner-led clinics—all of them?

Ms. Camille Orridge: Thank you for allowing me to clarify what was meant about payment for physicians. Yes, all primary care. Community health centres are now accountable within the LHINs.

M^{me} France Gélinas: The only primary care—

Ms. Camille Orridge: That's the only primary care that's currently within the LHINs. All of the other family

health teams: They all have contractual agreements with the ministry. We're asking that those agreements be managed by the LHINs.

M^{me} France Gélinas: Why?

Ms. Camille Orridge: Because then, like all the other providers who deliver care, those accountability agreements can be streamlined and we can get common agreements to deliver common outcomes for patients and populations. Right now, we can do that with a large portion of the system, but not all. Yet, for most of the people we see—the aging population—primary care is key and needs to be part of that care plan.

M^{me} France Gélinas: Okay. Then, if it is important for you to be the one negotiating and harmonizing service agreements or accountability agreements with the primary care sector, how come you didn't ask for the same thing for the home care sector? You're not the one who negotiates the contract with the home care sector providers. How come you didn't ask for those?

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Ms. Camille Orridge: We fund several of the folks—when you say "home care," what do you mean? The CCAC we fund, we have agreements with, we hold them accountable for delivering of care. For some of the community agencies, we hold those accountability agreements, so those all come together in terms of delivery of the care to the patients.

M^{me} France Gélinas: Yes, but there are many, many contracts out there that you do not negotiate. All of the contracts that the CCACs negotiate are not with you. Why is it that you're asking to negotiate some of the contracts and be in charge of some of them in some parts of the health care system but not in others, and in other parts where you're already there?

Ms. Camille Orridge: So in all of the folks that we have contracts with—like, we have contracts with the hospitals. We do—

M^{me} France Gélinas: I'm talking about home care.

Ms. Camille Orridge: Right. But, as an example—and I'll use home care—we don't hold the contract they have with the oxygen and all of those. They manage all of those contracts to deliver the outcome we ask for. We do the same thing with the community agencies and with the CCACs. So if there's a different question as to whether or not those contracts should be held by the LHIN, we hold those contracts. We see that as holding the CCAC accountable for the delivery, and they, in turn, do that work. So that's why we did not specify that.

But for the primary care, we would like to see primary care being in the fold, just like we have the CCAC and the hospitals and long-term care.

M^{me} France Gélinas: Okay. Why not home care agencies? Why do the home care agencies have to go through an intermediary? Why do they have to go through the CCAC? You already have expertise in negotiating. You've already told us you do 1,400 of them. You want to do more, including all of the IHFs, as well as all of the primary care providers. Why not the home care providers?

Ms. Camille Orridge: At this point, the LHINs, through the legislation, the current legislation, do not do direct delivery of care. We have contracts with the CCAC. They deliver care, and the people they sub-contract with deliver care. So if the notion is that the LHINs should then also deliver those contracts, it's a role we'll gladly do, but it's not one that was in the original legislation, it's not one that we have done, and the model is that there is a separation of the planning and the management function at this time, and not the service delivery. It's been debated, discussed, but a final decision has not been made.

M^{me} France Gélinas: What is your preference?

Ms. Camille Orridge: I don't have a preference from the collective LHINs. My personal preference is that when I look across different jurisdictions, I see jurisdictions where the planning body also delivers services, and I'll see jurisdictions where the planning bodies do not deliver services. I've seen both work and I've seen both fail. My personal preference is more the one where the planning body does not deliver services.

M^{me} France Gélinas: Okay. My question was not to deliver the home care services. My question is: The money goes to the LHIN, the LHIN transfers it to the CCAC, and the CCAC holds the service agreements with a number of home care agencies. You hold service agreements with 1,400 service providers—

Ms. Camille Orridge: Yes.

M^{me} France Gélinas: —why can you not hold those contracts also?

Ms. Camille Orridge: It's possible.

M^{me} France Gélinas: And how come you didn't talk about this before?

Ms. Camille Orridge: Because it was not an agreed—we did not agree that that was a change in the model. The current legislation says to have that separation, and so we did not approach it that way.

M^{me} France Gélinas: Okay. Coming back to primary care, if your recommendation number 1, "The first recommendation is to give the LHINs greater responsibility for ... primary care," so aboriginal health access centres, nurse practitioner-led clinics, the FHNs, the FHGs, the FHOs, all this comes under the LHINs?

Ms. Camille Orridge: Yes.

M^{me} France Gélinas: What happened with the fee-for-service docs?

Ms. Camille Orridge: The fee-for-service physicians, currently—we have now seen about 80% of the physicians in Ontario moving into group practice. We now see all of the new grads moving into group practice. We see a significant decrease in fee-for-service. We do think that there are geographical areas where the fee-for-service docs still exist, mostly in downtown Toronto and some other areas.

I think there's an opportunity that those fee-for-service docs should also have contracts, and the contracts should be managed as part of primary care. There's a difference between us talking about fee-for-service docs and primary care teams. I think we are saying that we would

like to see more and more movement, that primary care is all delivered in teams, and that the team has a contract within the LHIN.

M^{me} France Gélinas: I couldn't agree more. But then I come back to your opening statement, and you leave me puzzled as to how you can open up by saying something that, then, you say you don't support when I question you.

Ms. Camille Orridge: I guess I'll try and clarify again. What we are talking about is that we do want those contracts—so thank you for the opportunity to clarify. We do want those contracts. What we were saying we were not asking for was to have that right to negotiate the cost and the salaries. We think that should remain, like so many other negotiations, central, but we do want and are asking for the right to manage all of those agreements.

M^{me} France Gélinas: Okay. I want to talk about another topic that you didn't talk about at all in your report but that we've all raised: There are areas of the province where the LHINs are hated. People have organized together. They've bought the T-shirts. They are beating down the door to come and be heard. They have been wanting to be heard for months; that turns into years that those people have been wanting to be heard. They are not happy with the LHINs. How did we end up there?

Ms. Camille Orridge: I have not had that experience myself, but I have spoken to my colleagues and so I am aware and have some knowledge about the issue.

The LHINs have a unique mandate, and it is that we have to listen to our communities. This perspective from our communities is really invaluable to understand the system, how it's designed and how we provide care. We do listen carefully, and we have certainly learned from the Ombudsman's report and the auditor's report where that has not occurred in the past, and all LHINs have reviewed that and learned from that, and we are all listening. The information we gather from our community engagement helps us to solve problems.

But in addition to bringing the patient perspective to health care planning, we also have a responsibility as system managers to advance the mandate of the government. This often involves difficult choices. We also have to manage things such as safety and quality, and sometimes those also mean difficult choices.

M^{me} France Gélinas: Let me give you an example: You go into a community where the community gets together, you put in a ton of work, and the community decides that the best way to overcome those barriers to access to primary care for a community is to have a community health centre. The ministry has a position that there's not going to be funding for new community health centres. So you have a responsibility to advance the mandate of the government, which is no new community health centres, and you have a responsibility to listen to the people you are there to serve. The population has spoken and said that the only way to give access to this particular community is to look at putting together a community health centre. How do you handle your

responsibility to listen to the people who you are there to serve versus the government agenda?

Ms. Camille Orridge: I would say we do that every day, and each LHIN does that in a number of ways. One is that we would certainly listen to what the community says. We would take that to the powers that be and say, “There is an issue here. This community needs access to primary care. If it’s not a community health centre”—I’m not sure why that decision was made—“what else are we going to do, because we still have to provide access”—and through that, would then hopefully work through and negotiate to get what is required in the community, which is access to primary care. I wouldn’t commit that it would end up being a community health centre, but we should still be working to get what is required, which is access to primary care.

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So that’s the role we play, as LHINs, all the time in trying to bridge those gaps and bring those sides together and find solutions.

M^{me} France Gélinas: Interesting. To those people who are very unhappy with some of your colleagues, what do you recommend we do? How do we bring those people back on board when people campaign to make sure that Ontario gets rid of the LHINs because they are not happy with the work that they have done? They have been wanting to be heard for a long time; nobody has listened to them. We’re about to embark. I guarantee you, we will hear it loud and clear. How would you respond to those people?

Ms. Camille Orridge: I would say that health care is fraught with tough decisions, and the LHINs’ work is to listen and to make that happen.

I would also say that I’m not sure, I don’t have any information, that that feeling of dislike, anger—T-shirts—is across all the province.

M^{me} France Gélinas: No, it’s not; it’s in pockets.

Ms. Camille Orridge: It’s in pockets. I would say, then, to go through a structural change where you then refocus resources, all of those things, to address that issue may not be the appropriate way to go. However, I think there needs to be, where those issues still exist, an all-out effort now to bring all the sides together, to say, “How do we work through this and pass this?” There will always be difficult issues that need to be worked through, and I’m not sure we can always change structure because of that each time.

M^{me} France Gélinas: Why do you figure this has not been done in the last three years?

Ms. Camille Orridge: I don’t know, specifically, where it hasn’t been done. I know, specifically—

M^{me} France Gélinas: Do you want me to give you an example? There are people in the Niagara Peninsula who are so angry that they have bought yellow T-shirts; they are waiting for us; they will be there by the hundreds. They’ve tried to go to their LHINs; their LHINs were closed. The meeting rooms were not adequate; they would not listen to them. By the time they finally got a

hearing, the decision was already made. They’re not happy.

The value you add is to give people a voice. If you don’t give people a voice but you take your direction from above, from the ministry, and you implement what the ministry wanted—the ministry doesn’t need you to have our wishes put on the ground. The minister is the minister, and it goes as she sees fit. What is the value of the LHINs in their eyes?

Ms. Camille Orridge: I would say that it’s—“unfortunate” is too easy a word to say about what has happened in Niagara and how that continues to play out in Niagara. I think all parties involved in that need to try to address that. I would just be concerned that what has happened in Niagara then gets translated to all LHINs across the rest of Ontario. That would be the only concern that I would have. I do think that issue occurred; it needs to be addressed, but I’m not sure that that should then be the sole reason for other action, versus focusing on addressing what is still the outstanding concern.

M^{me} France Gélinas: Another area you didn’t touch at all is the boundaries. Do you have any recommendations for us? Some groups will come forward with recommended boundary changes. Is there anything you want us to hear?

Ms. Camille Orridge: Yes. I would say that the question of boundary changes should be discussed if we’re hearing that it’s impacting patient care. If it’s impacting patient care, then, yes, the ministry should bring folks together to come out of this committee and then we should look at it. But I think to change numbers, boundaries, because of some other perception of a number wouldn’t be the way to go. But if there are clear areas of concern that have been raised, then yes, I think it should be advised, the ministry should hear it and we should all look at it, and make those decisions based on that.

M^{me} France Gélinas: Given that your primary mandate is to listen to the people you serve, have you heard of any groups that would like boundary changes?

Ms. Camille Orridge: Speaking provincially, there are areas in the province where the boundaries—I have not heard any questions about the boundaries. I have heard the boundary issue predominantly in the GTA and predominantly in two areas of Toronto.

M^{me} France Gélinas: Which are?

Ms. Camille Orridge: Donna Cansfield’s geography, where that particular geography is in Etobicoke. I would say, yes, it has been raised. Patient care concerns have been raised and I would say, yes, they need to be raised and they need to be looked at. I don’t have a concrete answer on that, but I do think it should be a decision based on patient care and patient flow.

M^{me} France Gélinas: Another area that you don’t touch on at all is the French-language service entities that give recommendations to the LHINs. You talk about First Nations, but not about the French-language ones. There are a number of them that have made recommendations to their LHINs, to be completely ignored. There is another group that is not too happy with some of your

members. Any ideas as to how we ended up there, and any idea how we make it better?

Ms. Camille Orridge: Again, for clarification, what I mentioned about the aboriginal was that the legislation—and I don't remember the exact wording, but the legislation talked about enacting services for French and aboriginal. The entities came about through the enactment of the French, but the aboriginal was never enacted. So the point I'm making is that that, too, should be enacted. That's a different question from this one, but I just wanted to clarify why I've mentioned aboriginal but not French.

The French entities certainly have made recommendations. There has been a lot of work, as far as I'm aware, with the LHINs and the French entities in terms of delivering French services. I would like to know more about specifically where those concerns have been raised. It's not something that I'm familiar with or aware of. I know that Toronto Central managed with a French entity for three LHINs, and all the working relationships that I'm aware of are that we meet together all the time, we share things, and all of their recommendations we have been working on. But I think it would be good to hear that to be able to address it.

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll now go to the government. Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Ms. Orridge, for coming before us. I know that you're representing all 14, and that's obviously quite a challenge, so thank you for giving us the presentation that you did, drawing from a number of different examples. Trying to transform health care and move to a more community-based way of operating is obviously a very challenging one.

Thank you for making some recommendations. The first one that has attracted some attention is a particularly bold one, I would say. As a physician myself, I know how difficult physicians find change. I'm wondering: In the fact that you are proposing greater responsibility for primary care, have you talked with any of the associations of family health teams? Have you initiated some of these discussions, either as the lead for the 14 or within Toronto?

Ms. Camille Orridge: Yes. Across all the LHINs, a lot of work has gone on in primary care. I can say that South East LHIN was the one that was out in front, doing a lot of work with primary care. The LHIN and family health teams work well together. I know in Guelph that the primary health care team there and the LHIN have worked well together, and they've included other providers like the city, the municipality, in working together.

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In downtown Toronto, I can say we have a number of family health teams. Two of our health links are actually led by family health teams: Taddle Creek and one in the east. So there's really good engagement. There are a number of solo docs that we are just now reaching out to engage, and that's a horrendous task.

Each LHIN now has primary care leads, and they go out and are working with primary care physicians.

So a lot of work has been happening between LHINs and primary care, even without this.

Ms. Helena Jaczek: So you do have some allies out there. In other words, there are family health teams that are embracing this opportunity. Is that correct?

Ms. Camille Orridge: Yes.

Ms. Helena Jaczek: Could you give us an example of where there has been a barrier? You have been talking a lot about patient care and how it matters if it is impacting the patient. Could you give us an example of where not having this responsibility has been a barrier to good patient care?

Ms. Camille Orridge: An example I would give is in downtown Toronto—and this may happen all across—where, on the books, you would say there are a number of primary care teams and a lot of primary care physicians, but 60% of who they see do not reside here. Therefore, we have pockets of people who do not have access to primary care. I know that's true in the north, and I know that's true elsewhere as well. But people often don't think of that in, say, the downtown.

In beginning to work with the primary health care teams, I can truly say family health teams like St. Mike's, Taddle Creek—when we have met and said, "This is the issue," they have stepped up, and they have started to change their practice to make sure that these people who live in their neighbourhood, and some of which are the most complex, are now being attached. So if we look at patient attachment to primary care, we have had a significant increase in the amount who have been attached to primary care in the last two years.

Ms. Helena Jaczek: As an example, say a person was to go to St. Mike's emergency department for a condition that they're going to be, obviously, discharged, not hospitalized, what you would envisage would be suggesting to that patient that they immediately attach to a family health team. Is that how you would see that—so people don't get lost, as you say?

Ms. Camille Orridge: Yes. What we have in place now is that out of that emergency department, they would call Community Care Connects, which is a program run by the CCAC. Their role is to attempt to make sure they get connected to primary care.

We also have, in the health links, a number of the primary care teams that have made a commitment to admitting these individuals. So we're seeing more and more of these individuals being admitted to primary care through the health links agreements that have been reached.

Ms. Helena Jaczek: That's good to know.

Your second recommendation is related to, essentially, multi-year planning, allowing the LHIN to hold surplus funds. Explain it to me so I'm really clear. You allocate funding from the LHIN to save—let's use the CCAC. At the end of the year, for some reason, the CCAC might not have utilized all of its funds, but they have an idea for some sort of new program the following year. They would reallocate that funding back to you, and you would hold it, pending a new agreement, I presume.

Ms. Camille Orridge: Yes. Right now, at the end of the year, all funds not spent within the year in the community sector go back. But very few initiatives of the kind of change and the change management we want to deliver in the system can really get done in a year, or can start in September and be finished by March. So what we're saying is, if we then are able—and it incents us to generate savings, because, “You know, if I do this and I save this, I can apply this to this project, or I can continue it after April to finish it.” That's not feasible now, and that's what we're asking for.

Ms. Helena Jaczek: So your accountability agreements with, say, the CCAC are annual, just one year at a time? How long is the agreement with them?

Ms. Camille Orridge: I'm not 100% sure. I think they're longer than a year, but the funding is annual.

Ms. Helena Jaczek: I would have thought if the agreement was for three years or something, you would want to see a three-year plan. But the intention would be multi-year planning and budgeting accordingly that would fit that?

Ms. Camille Orridge: Yes.

Ms. Helena Jaczek: Okay. I would think one might want to tie the agreement to some sort of planning that would allow for that.

Ms. Camille Orridge: Probably, yes.

Ms. Helena Jaczek: Okay, I get the picture.

Your third recommendation—I found this rather cryptic, the way it's worded. Your last sentence was, “While LHINs have had considerable success in collaborative governance in some areas, maintaining collective commitment to system goals can be a challenge.” Could you give an example so I can really understand what the issue is?

Ms. Camille Orridge: Most organizations are under the Corporations Act. Under the Corporations Act, if you're a board member, your obligation is to that corporation; so if the budget is short or if you're making a decision, you're making a decision for that corporation. We're saying that's not good enough. You need to be able to do both. You need to be able to say, “No, I also have an obligation to the system.” Some of the time there will be tension in those decisions, but you can't just make your decision in that silo, because the impact may be on the rest of the system.

That's where the LHINs have been bringing everybody together to make sure that we understand decisions, and saying, “No, sorry, that will impact this other hospital or impact the community or impact patients, and you can't really do that.” Our agreement allows us to say that from a funding point of view, but we would like that to be also part of the governance accountability as well.

Ms. Helena Jaczek: How would you make that work? Are you trying to say that the legislation that we currently have in the act should be changed in some way to require that those service provider boards have a clause in their bylaws or something?

Ms. Camille Orridge: Yes. We have included one that talks about patient engagement, community engage-

ment—asked them to include certain things. We're suggesting that there be some wording that addresses the need to be system players as well.

Ms. Helena Jaczek: Would you have a concrete example where the fact that this isn't right there in writing has impacted on patient care?

Ms. Camille Orridge: I'll give you an example where I know it was the goodwill that made it happen—but goodwill is always about the people at the table at the time, so if that goodwill changes, it would not happen. It's easier to be concrete from a Toronto perspective, but this is happening all across the province.

If I look at the stroke example, when you've got all the hospitals coming together and you look at where the patient went in the ambulance and how many patients a hospital should have in order to have a functioning, well-equipped stroke unit, and you've got a major hospital saying, “We do not have enough of these patients, so we should move this service from this hospital to this one”—and they voluntarily did that—that's not always happening, but some of the time that's what is required. So it happened, but it made us very conscious that if it's not voluntary, even those kinds of good patient safety things don't happen.

Ms. Helena Jaczek: Okay. I understand where you're coming from.

The final recommendation is to reduce the administrative barriers to integration. Does that not connect with your previous—you're saying at the board level you want to have agreement on integration more readily.

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Ms. Camille Orridge: It's not all about integration; it's an obligation to be a system player, right?

Ms. Helena Jaczek: Okay.

Ms. Camille Orridge: And system players are not always all about obligation. Sometimes it's about sharing resources. It's about not being able to say, “I offer this program, but I only offer it to my patients versus all the people in the community who need this service.”

Ms. Helena Jaczek: That's what you mean by administrative barriers: within the organization, sharing human resources or—

Ms. Camille Orridge: No. That first example is about being a system player. The example of integration is that it has some very set rules and timelines, but as you do this work, after a number of experiences, those don't always play out as efficiently as they could. So we will wait for 60 days because it says 60 days, even though all the parties have already agreed to do something; they've already done the community engagement; they have done everything, but there is a clause that says you must still wait another 60 days. Those are the barriers that we're saying that, after the experience, we should re-look.

Ms. Helena Jaczek: So there are unnecessary delays.

Ms. Camille Orridge: Delays, yes.

Ms. Helena Jaczek: Okay. You have been talking a lot about the patient perspective, and my colleague from Burlington talked a little bit about the whole issue of patient satisfaction and so on. Can you share with us a

little bit about what progress you've made in terms of looking at that aspect?

Ms. Camille Orridge: Yes. The difficulty with answering the question about patient experience as one metric and why it's taking so long is because patient experience is made up of a number of components, such as access—if you can't get access, you're not going to be satisfied. But if you get access and the quality isn't good, you're not going to be satisfied. If it's delivered, but it's not safely done, you're not going to be satisfied. Patient experience is made up of at least six or seven different aspects. We are now gathering the data on each of those, making improvements in each of those, but we have a long list of places that we go to for the information to show that we are making improvements.

For example, we know we have improved on access, and we can provide you with the information that shows access. We are improving attachment to primary care. We have more people now attached to primary care than before. We now have the NRC Picker that collects patient satisfaction from all the various providers. We have surgical efficiency data. Cancer Care Ontario is beginning to generate reports about wait times—wait times for hips, wait times for knees, wait times in the emergency department. All of those data elements have taken time to build and to be in place. So we are moving towards being able to report on patient satisfaction across all of those, but it isn't likely that there will just be one measure to say patients experience. We're saying these are all the things that need to be done for patients to have a good experience. We have made progress in some, some we're just starting, and the data collection also takes a while to happen.

Ms. Helena Jaczek: On page 9 of your presentation, you had a couple of graphs. I presume this is aggregate across the province. Is that correct?

Ms. Camille Orridge: Yes.

Ms. Helena Jaczek: So we would be able to get this kind of data from our own LHIN.

Ms. Camille Orridge: Yes.

Ms. Helena Jaczek: Okay. What kind of relationship do you have with Cancer Care Ontario? How do your jurisdictions match?

Ms. Camille Orridge: We work with Cancer Care Ontario on a number of fronts. There's one table that brings together the LHINs, Cancer Care Ontario, the OMA, the OHA, and together, we all, then, work at, what are the systems issues and how are we going to work together towards them? So we do work with Cancer Care that way.

We also work with Cancer Care on a number of other initiatives, like dialysis, kidney disease, and so in each of those, we work with them in terms of, what are the deliverables, what are the outcomes they expect, and we work with them on wait times.

Ms. Helena Jaczek: Okay, but there are no accountability agreements going between you and—

Ms. Camille Orridge: Not at this point. We have had conversations about how we do that work together, yes.

Ms. Helena Jaczek: So that's something that could be pending and over time would potentially be worked on.

Ms. Camille Orridge: Yes.

Ms. Helena Jaczek: Okay. My favourite topic, boundaries, as I represent people in the Central LHIN—I think it's very important that you made the point that every day there are hundreds of thousands of people having interaction across the health care system, and we, in our offices, probably just get those complaints. We do get complaints, obviously; we seldom get accolades in our constituency offices. So it may be a small number of issues, but we hear about them.

I would say, from the perspective of the Central LHIN, that there are definitely issues in terms of patient care and the seamlessness which we're all striving for from a patient perspective, when they're hospitalized at a downtown academic health sciences centre or whatever and then they return to Central. This is no secret. I've talked to the CEO of my LHIN and the chair of the board about this kind of issue, and we forward these issues. I was glad to hear you say that there might be some issues around boundaries, particularly in the GTA.

One of our colleagues, the member for Etobicoke Centre—her constituents belong to one of four LHINs, so the boundary issue is very, very important.

If there were a desire to look at something for the GTA, could we count on the LHINs in the GTA to perhaps start looking at what might make for a seamless patient experience?

Ms. Camille Orridge: What I can say is that the CEOs of the GTA LHINs are now meeting monthly, and we are identifying those issues that are cross-border, and we are trying to address them one at a time, because for us, it should be seamless.

An example of two things that have happened—Central LHIN initiated a program around long-stay children needing to leave Bloorview. The accommodations were in Central, but the children were in Bloorview in Toronto. Central initiated the project, led the project; we agreed on it; we cost-shared the funding, and that has occurred.

The MCIT, the mental health—not having mental health services, police, health care services across the city of Toronto. We are doing some work now, co-chaired by—the Toronto Central LHIN asked the police and Toronto East General to co-chair this. They have now designed the program to cover the entire city of Toronto. A portion of it is in North York. We work together as the five LHINs. Toronto Central has funded it; Central, in turn, will pick that up.

So issue by issue, we are starting to work to address those issues. We are very aware of them. I think the boundary issue should come about through—there should be two discussions. One, let's address the issue so that patient care isn't impacted; then, let's look at that and see if and where there should be those changes. But I would separate those two things.

Ms. Helena Jaczek: Certainly, as you get more into the social determinants of health—and I see that, ob-

viously, from your perspective in Toronto, you know how important those are—any of those services are organized at the municipal level, the upper-tier municipal level and York region. So if you're talking supportive housing, if you're talking public health, if you're talking police, the justice system, that is all at the municipal level, which has different boundaries. I'm very glad that that's recognized and you're talking about it.

Ms. Camille Orridge: The other thing I would just like to add is that there is also—because that is really key—a table where the city of Toronto and the five LHINs come together. We're identifying what the issues are for the city of Toronto and saying, "Let's now problem-solve them." So, yes, there's work under way because it's identified as an issue.

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Ms. Helena Jaczek: Okay, thank you. I just have one last point. You talked about the data that you use. Essentially, you get your data from CIHI or ICES, the Institute for Clinical Evaluative Sciences. You don't sort of replicate that in-house in each LHIN. Basically, each LHIN is provided with the data required for your geographic area, pretty much, by ICES and CIHI, so there's no duplication; that's what I'm getting at.

Ms. Camille Orridge: No, the LHINs have actually worked well together to reduce—for example, the Toronto Central LHIN manages the IT for all 14. Wherever possible, we do that. When it comes to things like data analysis, Hamilton Health Sciences centre created—I know the acronym; we call them "DI." Toronto Central LHIN goes there, so all of our provider data goes there. We try as much as possible to not duplicate, or to share wherever we can. So no, we don't all build out those things ourselves.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Mr. Fraser.

Mr. John Fraser: What's left?

The Chair (Mr. Ernie Hardeman): You have about six minutes left.

Mr. John Fraser: I won't take the full six.

Thank you very much, Ms. Orridge, for coming today and presenting to us. Your presentation has been great; it's very informative.

Most of my experience has been, where I'm from—which is in Ottawa, which is the Champlain LHIN, which is in a bit of an ideal situation. Its geography is right and it kind of fits the model, so it has been a very positive experience, but there are some challenges. What I want to focus on is whether the experience that we have locally is replicating itself, to the best of your understanding, in the province. I know that from a public engagement point of view, our board meetings are held monthly. They're open board meetings. The public is invited. They're actually very well attended by the media. Is that something that happens across the board or is—

Ms. Camille Orridge: All LHIN board meetings are open to the public, all the committee meetings are open to the public, all our information is put up on our website

and my quarterly report to the board is posted on the website, so yes. As I mentioned earlier, all LHINs certainly took the auditor's report and looked through it. All the governors and all the boards did, and they made significant changes to ensure that the recommendations were embraced and implemented.

Mr. John Fraser: Would you say it would be a regular practice that boards travel to have their meetings? I know that, within ours, they travel to have their monthly meetings, so they would have them in a different community, say Renfrew or Arnprior.

Ms. Camille Orridge: To my knowledge, they do. I think that Toronto Central would be the only one that doesn't.

Mr. John Fraser: Yes. It would probably be problematic to move around.

There was one thing that you said that struck me, and I wanted you to elaborate on it a bit more. When people are at the table, that's when goodwill happens and when things get done. Again, I know this is the experience that we've had in Ottawa over a number of things, whether it's maternal newborn or hips and knees, where people put aside their interests to make sure that we could succeed in terms of providing better care. I know you gave the example of strokes, which is an excellent example. Are there any other examples that you might be able to point to? I know there's a lot of that. We're talking, in the health care system, about serving 13 million people with hundreds of thousands of providers.

Ms. Camille Orridge: Yes. I know that all the LHINs have engaged in these kinds of initiatives. I know that several LHINs, for example, just did a lot of work around transportation where they brought all of the providers together and have issued common transportation for non-urgent transportation. I know that has occurred. I know that Simcoe has done a lot of work in bringing all the providers together, and they have standardized a lot of the community services. They have streamlined it. The list can go on; we can send that. But every LHIN has a number of those initiatives, both in hospitals as well as in communities.

Mr. John Fraser: Just going back to your first recommendation about primary care, does every LHIN have a primary care lead now?

Ms. Camille Orridge: Yes.

Mr. John Fraser: I know it's relatively new. I think it's in the last year or so that they've been—I know they're identified in Champlain.

Ms. Camille Orridge: Yes.

Mr. John Fraser: Currently, what would their immediate mandate be, just so I understand?

Ms. Camille Orridge: Most of the primary care lead's role is to go out and engage primary care in the LHIN and engage them in the planning and then participating in the move forward about, how do we work together? How do we serve complex clients? What services do you need? What we have heard is that a lot of the primary care physicians need help from the rest of the

system in order to take more complex patients. It's not that they don't want to; it's that they need support.

The primary care leads engage them and then bring them to the table. Then, through health links, we're beginning to provide them with the other supports that they need. But their role is to work with the LHIN and to engage primary care providers.

Mr. John Fraser: The challenge we hear about is GPs who aren't really integrated.

Ms. Camille Orridge: Right.

Mr. John Fraser: They're doing their job. They're doing a great job, but they're not connected to the system.

Ms. Camille Orridge: Right.

Mr. John Fraser: So how do you see gaining that accountability? I think that's the biggest challenge in there. How do you see that working?

Ms. Camille Orridge: I think it's a two-way street. It's not only that these primary care physicians are not engaged in the system; it is that the system itself isn't organized to support them. The example that I gave earlier of a physician in his office with a patient who needs community care but would have to call 30 agencies, that's not a good use of a primary care physician. Now we have one number to call, so he or his secretary only calls once. We need to provide primary care with information. "You have a diabetic who needs diabetic education? Here is where you go."

Mr. John Fraser: So it's an accountability that goes both ways.

Ms. Camille Orridge: It goes both ways. We have to provide primary care with supports as well.

Mr. John Fraser: It's not just simply saying, "Here's what you've got to do for us."

Ms. Camille Orridge: No. We have to get the discharge summary to the primary care physician before the patient arrives after hospitalization. Those are all the things that primary care needs to do a good job.

Mr. John Fraser: It's to come to an agreement on shared responsibility for the patient?

Ms. Camille Orridge: Yes. That's the shared responsibility piece.

Mr. John Fraser: Thank you very much, Ms. Orridge.

The Chair (Mr. Ernie Hardeman): I think that was a very good answer. We'll stop there, and we'll go to the official opposition. Ms. McKenna.

Mrs. Jane McKenna: Hi. I have a first question: As a system manager in a LHIN, can you tell me if one of those job descriptions you have is finding solutions?

Ms. Camille Orridge: I would assume that it is. I don't necessarily personally have to find the solution, but I have to ensure that the solution is created, yes.

Mrs. Jane McKenna: Okay. So that would be just something you would do, or is that part of your job description?

Ms. Camille Orridge: I assume it's part of my job description as the CEO.

Mrs. Jane McKenna: Just picking up off of Ms. Gélinas when she was talking about Niagara: Just so I'm not putting words in your mouth, I just want to know when you said about the LHINs that you were hoping it wouldn't—and I might be wrong, so I just want to reiterate this—or that you didn't want the negativity to go to other LHINs, what did you mean by that?

Ms. Camille Orridge: Let me try to be clear. What I was getting at is, there are 14 LHINs in a large province and a large number of people who access the system. So yes, there's always room for improvement, and there are always going to be issues that aren't quite right. It may not be perfect in health care, and we're always working on continuous improvement.

So yes, there's an issue in Niagara. The issue that surfaced was in Niagara. I'm hoping that we have the opportunity to address that issue in Niagara. What I was trying to get at is that that issue, as significant as it is, not be the only issue that then determines what happens or the functioning or how LHINs performed generally across the province. That's the point I was trying to make. I was not taking away from the issue in Niagara, but I was also trying to say—because the question was, if you're hated there, should LHINs generally be supported? I was trying to make that point.

Mrs. Jane McKenna: A question is then—maybe you can't answer this; that's fine if you can't—if you're solution-driven, why can't we find a solution there in Niagara?

Ms. Camille Orridge: I don't know that we can't. I don't know it enough to be able to say whether we can or we can't. I cannot—I don't know.

Mrs. Jane McKenna: Okay. That's fine. That's all I have.

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The Chair (Mr. Ernie Hardeman): Ms. Elliott.

Mrs. Christine Elliott: Thank you, Ms. Orridge, for coming today, and for your presentation. I'm sorry I missed the first part, but I have read the paper. My question relates to the wait times and getting the wait times down in certain areas: hips, knees and cataract surgeries.

I've heard something rather disturbing recently, and I'd really appreciate your comment on it. I've heard from several physicians in this area that they have been told that it has been mandated through the LHINs, and it has been communicated to them through the hospitals that they work out of, that they are to optimize their data and that this has resulted in some reporting of data that is inaccurate. For example, if someone has been waiting for six to eight months for cataract surgery but it actually gets booked two months out, the wait time is reported as being two months rather than six to eight months.

Can you tell me, first of all, if there has been any kind of mandate through the LHIN to optimize data, and secondly, what it means to the LHIN?

Ms. Camille Orridge: I have heard nothing in terms of LHINs instructing anyone to optimize data. What I have known is that as LHINs, as we have been using data

for decision-making, we have asked folks to go back and look at data integrity and ensure that their data is accurate. What we have found during that is that, in a number of areas, the coding was not accurate. I know in one of my LHINs in particular, the way they coded, they did not code palliative care, which meant that when it came to the funding formula, they had lots of patients that they were not capturing. That was not optimizing the data for negative reasons. It was trying to make sure that the data integrity was good. I have not heard or know of anything about optimizing data in any negative way.

Mrs. Christine Elliott: Have you heard from any physicians with respect to any of these issues? Have any concerns been raised to you with respect to wait times generally in these areas?

Ms. Camille Orridge: Not in those, not in the hip, knee, cataracts, no. I've heard about wait times in the super-specialties, like ankle. We took that back as LHINs, and the ministry has responded, and we got some increases in OR times for those services. But I haven't heard anything else about that.

Mrs. Christine Elliott: The other thing that has been said to me by some of the physicians is that they've been told by the hospitals that if they make any complaints, their volumes will be cut. Have you heard anything about that?

Ms. Camille Orridge: No. That would be a—no. And I will ask my colleagues. It has not come up at any of our tables that that is an issue, and we meet regularly and raise issues regularly. That has not been raised.

Mrs. Christine Elliott: So this is obviously a matter of concern because it affects the credibility of the data, if it's true.

Ms. Camille Orridge: Sure, so—

Mrs. Christine Elliott: What would you recommend the physicians do if they are concerned about this?

Ms. Camille Orridge: Normally and in the past when these kinds of issues emerged, what the physicians would do, and what I would expect them to continue to do is, they would have taken it to the OMA, they would have taken it to the LHINs, they would have taken it to the hospitals, and the issue would be addressed. They have multiple places in which to take those issues.

I would welcome physicians getting back to us to say, "These are the issues." I have not heard it. As I said, my colleagues have not raised it at our monthly meetings, but I will raise it.

Mrs. Christine Elliott: Well thank you, and I'll certainly let those people know who have been raising those concerns with me.

Ms. Camille Orridge: Yes, I would certainly welcome hearing that.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): That's it? No further questions? If not, well, thank you very much for your presentation—very informative. We look forward to the committee digesting all that information.

Ms. Camille Orridge: Thank you.

SOUTH EAST LOCAL HEALTH INTEGRATION NETWORK

WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presentation is a dual presentation from the South East Local Health Integration Network and the Waterloo Wellington Local Health Integration Network, Paul Huras and Joan Fisk. Paul is the chief executive officer of the South East LHIN, and Joan Fisk is the chair of the Waterloo Wellington LHIN.

Paul, welcome. It's good to see you again. It was quite a while ago you were head of the—what was it, the health council?

Mr. Paul Huras: The Thames Valley District Health Council.

The Chair (Mr. Ernie Hardeman): Thames Valley. I knew it was something like that. It's good to see you again.

Mr. Paul Huras: I read a nice article about you in the paper, in the London Free Press, on Saturday.

The Chair (Mr. Ernie Hardeman): That's right. The only reason it only appeared once: I couldn't afford it a second time. But thank you very much.

As previously, we give you half an hour to make a presentation. You can use any or all of that. We will then divide the time that's left equally between the three caucuses for asking questions. Normally, they get a set time, but we're going to be short of time, so when you're finished with your presentation, I will then decide as to how we divide the remaining time. Thank you both very much for being here. The floor is yours.

Mr. Paul Huras: Great. Thank you very much. First of all, thanks very much for the opportunity to speak with you about LHSIA and the local health integration networks. You have an important and demanding job, but I know you take these responsibilities seriously, and I trust and truly respect each of you in your commitment to improve this important legislation. I hope you find my insights contribute to your task.

My experience includes working in health research centres, district health councils, hospitals and community care access centres prior to my role in building the LHIN model for over eight years now. I am speaking to you about my own experience in the South East LHIN, but also from a provincial perspective on the LHIN role and the success of the Ontario model, as one of the original LHIN CEOs who has been here since the beginning.

With a significant decrease in bureaucracy, local health integration networks have led improvements in health care performance across their regions and together across the province. Specifically, access to care has greatly improved. The Canadian Institute for Health Information reports Ontario is the only province to reduce wait times. In the South East, because of new programs, such as the short-stay unit that we implemented at Hotel Dieu Hospital, and our role in a better way to do allocation and in-year re-allocation of volumes, people in the

South East wait seven months less for hip and knee replacement surgery: 140 days now instead of 380 days in the past. Those are numbers, but what's important is that's seven months pain-free.

More people have a family doctor. Because of the introduction of Health Care Connect through the province, in the South East, 96% of the population report they have a family doctor compared to 80% before the LHINs. Health Care Connect, in fact, was an idea generated in the South East from engagement with local primary care physicians, which has now been rolled out provincially.

More seniors are able to delay hospital admissions, delay moving into long-term care and return home sooner from the ER. Because of programs like SMILE—that's Seniors Managing Independent Living Easily—designed by local seniors and developed by the South East Local Health Integration Network, and programs like Home First, first developed at the Mississauga Halton LHIN and now adopted by all LHINs, emergency visits by seniors decreased, alternate-level-of-care patients are more appropriately placed and wait times from the community to long-term-care homes have been reduced in the South East.

The cost curve is bending, and hospitals are balanced as a result of the management by LHINs of their accountability agreements. These agreements allow us to intervene if financial or program performance is not what is expected. Because of the service accountability agreements, the South East hospitals are balanced, even though there have been decreases to the funding to five of our seven hospitals as a result of the new health system funding reform.

In addition, in the South East, we have initiated the financial turnaround of several health services providers, including hospitals, requiring performance improvement plans, or PIPs. We don't believe it's acceptable for someone who is a health care leader today to say, "I have a problem. We need more money." We, in fact, have changed the culture.

The administration of health care has become more efficient. Because of the work of the South East LHIN, over 40 community care providers utilize a common system for payroll, financial reporting, maintenance of enabling technologies and human resource services. The seven hospitals in our LHIN have a single benefit plan. They have developed 3SO, which is a common supply chain management system. They have just committed to pursue a single computer platform and have contracted for a single non-urgent transportation system.

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For the first time in Ontario, as a result of the LHINs, we are measuring health care performance. We are setting targets based on these measurements, and we're actually achieving results.

LHINs are developing plans which are based on patient experience. In the South East LHIN, our addictions and mental health redesign is based on the client and the family experience. It is changing the way we think services should be delivered: shifting from episodic care

to providing support where necessary during the client's life journey and linking more closely with providers outside of health care, like housing and social services.

These are just a few examples of how we have been able to make a difference in the South East. Similar stories could be told across the province of LHINs improving access, improving services and making health care more efficient.

The Ontario model of health care devolution: I want to talk about that for a moment. Devolution of health care decision-making to regional entities has occurred in every province in Canada, even Alberta. Alberta had it, and then they changed it dramatically, but it's still considered devolved decision-making. What is unique about the LHIN model is the alignment of priorities and accountabilities throughout the province. Devolution should not mean every region does what it wants. In Ontario, it means the Ministry of Health and Long-Term Care sets provincial priorities and holds the LHINs accountable for improvement through the ministry-LHIN performance agreement.

The LHIN takes those provincial priorities and adds local priorities based on the unique needs of its population. It holds the health service providers accountable through service accountability agreements, H-SAAs, M-SAAs and L-SAAs. Health service providers then use these priorities for their programs and staff and hold them accountable.

In Ontario, there is alignment from the minister right to the front line. In Alberta, I understand that was not the case when they had, last, nine regional health authorities. I've been told by the deputy minister in Alberta at the time that, because of the severe lack of alignment, that province made the drastic changes that it's struggling with today.

Another thing that makes Ontario different from most other systems is that we continue to have independent health service providers with their own boards of directors. I believe this makes our system stronger and more innovative. But it means that we need all of these providers working together and thinking like a system.

LHINs are committed to improving access to high-quality care through the development of regional systems of integrated care. In the South East, we provide \$1.1 billion to 124 different health service providers and their programs. The service providers and their staff who deliver these programs are dedicated, hard-working and innovative people. But for the most part, these organizations have worked independent of other organizations.

LHINs are demanding regional thinking, and we are seeing system leaders emerging. These leaders are realizing that (1) working as a system has more to offer a patient than any one organization can offer itself, and (2) only when an organization works together with other organizations, pursuing a common vision and resolving variations in care protocols, can they truly be responsive to the needs of the patient.

Like all regionalized health care models, there will always be questions about the number and the size of

regions. Although some call for fewer LHINs, some call for more LHINs. On average, LHINs serve roughly 900,000 people per LHIN. That is more, on average, compared to any regional health authority except the Alberta model.

Although some say the borders are not perfect, the reality is that no border division can be perfect: When you have a near-perfect referral pattern for an area such as cardiovascular health, you probably have a very imperfect border for addictions and mental health and other services. What's perfect in one area may not be perfect in another area. The LHIN borders were developed based on the analysis by the Institute for Clinical Evaluative Sciences of the referral patterns in the province. For example, in the South East, 96% of the residents in the South East receive their care from providers in the South East, making it very self-sufficient. It may not be a perfect boundary, but it would be hard to beat.

I have been told by regional health authority CEOs that when they have revised their boundaries, they have seen significant disruption in their care delivery post-realignment. My point is that I believe boundary changes don't achieve much, and they take energy and commitment away from patient improvement.

Roles of LHINs: Local governance is central to the LHIN model. Our board members are part of our community, and they engage with health service provider boards to promote regional thinking and integration.

LHINs are governed by a nine-member board, as you know, appointed by orders in council and accountable for oversight of the LHIN's operations and for engaging health services provider boards. LHIN board members are appointed based on the skills they bring to the table.

LHINs are health system managers. As system managers, LHINs rarely need to dig into the day-to-day operations of a particular organization. Instead, LHINs are able to focus on the system to improve performance and access to high-quality care. This allows us to focus on our mandates, which include local health system planning, integration, funding, accountability and performance, and community engagement. I'll talk about each of those in a bit.

LHINs lead local health system planning. LHINs conduct local planning using detailed quantitative analysis and qualitative analysis. In the South East, for example, our quantitative analysis includes looking at seven to 15 sub-regions in the LHIN, breaking the data down by age, sex and other factors. We develop population projections, we apply health service utilization rates to these projections, where available, and we also apply prevalence and incidence rates to determine future demand. We then analyze current capacity and potential capacity which could be achieved through system integration or clinical innovation.

Our qualitative analysis brings in the community perspective through community engagement to put the data in context and to understand what is working well, what is not working well and what improvements are

necessary. Some of the things we do in the South East to engage our communities include citizen panels, open houses, web-based workbooks, web-based surveys and community development planning processes, as well as health service provider engagement.

LHINs promote and lead integration. Integration is about health service providers developing partnerships and agreements to ensure their component parts work together to meet the needs of patients.

LHSIA defines integration, including facilitated and voluntary integration, as well as the LHINs' role in supporting and driving integration. This includes horizontal integrations, or partnerships between providers in the same sector; hospital to hospital, such as the seven hospitals in the South East working together as a regional system of integrated hospital care with clear roles to achieve coordinated on-call coverage, common transfer protocols and repatriation procedures, common medical human resource planning, recruitment and credentialing. All those are what we are striving for in the South East. Also vertical integration, or partnerships between providers in different sectors, within sub-LHIN geographies: These partnerships are linking hospitals with CCACs, addiction and mental health providers, long-term-care homes, primary care and community support services.

We also have the responsibility of funding. LHINs allocate over \$24 billion in yearly operating funds, with nearly 2,000 service accountability agreements. The South East LHIN alone has the responsibility to allocate \$1.1 billion, with over 100 service accountability agreements.

LHINs allocate new funds, such as the 4% community sector increase, which goes to selected health service providers to address provincial and local priorities. LHINs also reallocate community sector projected surpluses to ensure maximum value of the LHIN-specific envelope. The South East LHIN sends out close to 1,000 funding letters each year.

Accountability for performance: All LHINs negotiate service accountability agreements with each of their providers. This is one of many examples where we work together provincially. LHINs work together and with our sector partners provincially to achieve a common template and schedules, including common measurement indicators. There is one for each sector: hospitals, long-term care and the community sector. These agreements are then executed regionally, where we work locally to achieve specific details for the schedules, including health-service-provider-specific performance targets.

LHINs constantly monitor performance of our providers, and when a provider is failing to perform, we analyze the problems and work with them to address them. If performance continues to be an issue, the LHINs approve a performance improvement plan and conduct quarterly or monthly reviews.

LHINs engage our communities. Every year, across the province's LHINs, thousands of people are engaged in discussions about services in their communities, what is working and where we can improve. Each LHIN en-

gaged thousands of people from the general public annually. Each LHIN engaged hundreds of patients annually and hundreds of providers monthly.

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In the South East, we engaged around 1,000 residents to inform our hospitals' clinical services roadmap. Our most recent Integrated Health Service Plan included web surveys, where people would actually get on the web and spend 15 minutes to complete a workbook. Sometimes they would complete seven workbooks on different services at 15 minutes each. Sometimes they were completing these at 2 o'clock in the morning. People said, "That won't match your demographics." In fact, it did. When we looked at the demographics of the people who completed these workbooks, they matched the demographics of our region. During the development of our additions and mental health design, we have engaged an additional 600 individuals, close to 250 of whom were clients and families.

Community engagement is one of our core values. LHINs have worked together to develop a common community engagement guideline and a common decision-making and priority-setting framework that reinforces the importance of engagement to ensure transparency and improve satisfaction. I believe that engagement has resulted in better decision-making about adjustments, improvement, development and funding.

Now to talk about transformational change: Given the growing demands on our health care system, all LHINs are focused on transformational change. Transformation is required today because of two key environmental factors: (1) today's economic reality and (2) the patient of today.

Today's economic reality: Health care is fortunate to have 2% of the annual budget increase, but this is much different than the 6% to 12% that health care has been used to in the past. The 2% is actually 0% for hospitals (much less for the South East hospitals) and 4% for the community.

Today's patient is very different than the patient for whom the system was originally designed. Our health system was designed for the patient who had an acute episode. It was built around hospitals and an assumption that after their hospital stay, the patient returned to full independence at home. But the reality is that most care is provided in the community. When we think of today's patient, they may be suffering from multiple chronic conditions, which they will have for life and for which they require a care plan involving multiple care providers working in sync to wrap care around the patient.

These two realities are demanding completely new ways of working. I'd like to highlight a few examples of the transformational change under way in LHINs today. The first one I'll talk about is quality. The Excellent Care for All Act has been instrumental in focusing every part of the system on the quality care that we deliver. It requires health service providers to develop quality improvement plans, beginning with hospitals, the CCACs and now also primary care. LHINs review these plans.

Additionally, we know from our engagement of patients and the public that, generally, people are pleased with the quality they receive from their health professional, such as their doctor or their nurse; generally, people are pleased with the quality of care they receive from their health care organization, such as the hospital, a CCAC, long-term care etc.; but, generally, people are not pleased with the quality they receive from the system. They reference a lack of information transferred from one provider to the next prior to their visit, lack of medication reconciliation, lack of timely test results and having to repeat their story. Integration of services is and will continue to have a huge impact on improving quality care, while producing greater value for the same level of funding.

The health services funding reform: Funding hospitals based on a single common economic adjustment was archaic and perpetuated inequities. The new funding formula will contribute to equity across the hospitals by funding hospitals based on a 30% allocation for global budget, 40% for the uniqueness of the catchment population using the health-based allocation methodology—typically called HBAM—and price points and volumes for selected quality-based procedures, such as hips, knees, cataracts and kidney procedures. This means some hospitals will have increases to their funding, and some hospitals will lose funding based on redefining fair share. We estimate that the South East hospitals will actually lose between \$30 and \$40 million post mitigation.

More importantly, however, the new approach to funding hospitals is complemented with a new approach to building capacity in the community sector. The 4% increase to the community sector is program- and priority-specific and not for cost-of-living adjustments. It is being allocated to organizations which can assist higher complexity patients to come home earlier and stay home.

I believe that funding reform will actually strengthen hospitals over time by allowing them to focus on acute care services and giving us better information that links together quality and costs.

Health links: The LHIN model does not currently include all of primary care, only Ontario's 108 community health centres. Health links, which I know Camille spoke about earlier, are giving us new ways to engage primary care providers. Health links are accountable to LHINs and are being implemented by LHINs across Ontario.

Health links were designed to link health service providers together in small geographic areas to share resources to better meet the needs of patients. In the first instance, they will focus on patients with complex conditions, but eventually, health links will serve all types of patients.

Health links include primary care: Now primary care is on the same level as other health service providers in the determination of how best the providers, together, can meet the needs of individual complex patients. By bringing primary care to the table and by making all providers

in the local geography accountable, I believe health links are truly transformational. The model will build on the model developed provincially by the LHINs.

Soon the entire province will be covered by health links. Since they were launched, there are now 35 health links approved, and the goal is to have between 70 and 90. The South East has seven approved health links covering its entire geography. These health links will ensure patients discharged from hospitals will have primary care appointments made within 24 hours, medication reconciliation, coordinated care plans etc. They will be evaluated on 11 different criteria.

Health links now allow LHINs to indirectly invest in primary care providers that are members. Since health links are accountable to LHINs, LHINs can identify community sector priorities, ask health links to submit proposals and allocate funds to those health links which show the ability to perform.

Opportunities to improve LHSIA: As someone who has been with the LHINs from the beginning, I can say that I believe LHSIA is an important piece of legislation and has contributed to improvements in health care delivery over the past eight years. As you consider your recommendations, I hope that you will see the importance of maintaining the LHINs' strong regional population perspective, our flexibility for locally driven solutions and our commitment to community engagement.

But LHINs also see some improvements that could improve value: primary care, specifically. Regardless of the gains we are seeing from health links, all primary care needs to be accountable to the LHINs. If full integration is to be achieved, primary care cannot be left out. They play an essential role for patients and clients to help navigate the system, and they need to be part of our planning and accountability structure.

This does not mean making changes to how physicians are paid. Physician compensation remains the purview of the Ministry of Health and Long-Term Care. Billings would continue to be through OHIP, and I believe that's the case in all regional health authorities.

Independent health facilities: Independent health facilities provide community clinics. These clinics can help lessen the demand on hospitals in a more cost-effective way and improve access to services locally and in the community. As part of the health system, they need to be accountable to the LHINs so that we can ensure these clinics are contributing to improved access and delivering value for money.

Defining health service provider responsibilities to the system: As I said earlier, many health service providers see their responsibilities as primarily to their organization. LHSIA requires providers to engage the public and participate in integrations, but boards need to see themselves as part of a true system of care. Provider boards need to have responsibilities to the system as well as their own organization.

More flexibility to allocate funds: There are some provisions in LHSIA today that haven't been acted on and that have the potential to benefit the system. One of

these is greater flexibility to utilize projected surplus funds. Allowing LHINs to utilize and to retain surpluses into the next fiscal year would give us a better ability to fund larger and multi-year change initiatives that benefit the patients.

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In summary, LHSIA has taken the new model of health care devolution in Canada—Ontario's LHINs—off on a great start to improving health care in the province. In fact, I have been told by regional health authority CEOs that it is time for them to start paying more attention to LHINs as they are achieving results that have escaped their grasp. LHINs have proven the models work and work well.

This review of LHSIA is timely. Like all new systems, the model should be reviewed and improved as we evolve and grow. Ontario needs to continue its leadership in health care improvement. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. Ms. Fisk, do you have a presentation, too?

Ms. Joan Fisk: No; I'm here to support the governance model.

The Chair (Mr. Ernie Hardeman): Oh, very good. I was going to say he did a great job with his presentation, but he used up almost all the time—

Ms. Joan Fisk: Yes.

The Chair (Mr. Ernie Hardeman):—so I didn't know how I was going to share that.

With that, we will have about 20 minutes for each caucus. We will start with the third party. Ms. Fife.

Ms. Catherine Fife: Thank you for the presentation and the overview of the South East LHIN to the standing committee

One question: You've mentioned independent health facilities here on page 9. This is an area that I think we need to be careful and cautious about. One of the trends that has recently come to our attention, not only in Toronto but in southwestern Ontario, is the outsourcing of specialist procedures to community clinics. You reference here that this is a more cost-effective way to deliver services.

The research, from what I've read, and I've read both sides, is that the cost-effectiveness of outsourcing specialist procedures to community clinics is questionable. In particular in our region, gastroenterology is being referenced outside of the hospital setting, which is a concern for us because the farther you get from LHIN oversight, the farther away you get from true accountability, in my estimation. Do you think you can comment on that, please, Paul or Joan?

Mr. Paul Huras: Yes. Just to be clear, Joan and I agreed that I would handle most of the issues related to operations, and Joan would handle questions related to governance.

Ms. Catherine Fife: Sure.

Mr. Paul Huras: I think any system or program has the risk of being inefficient if there aren't certain rules and regulations put in place and accountability agree-

ments. Being part of the LHIN environment, having a service accountability agreement, allows us to ensure that there are performance targets, including volumes agreed to for the price that's allocated. Therefore, we would have the authority to be signing an agreement with an independent health facility to ensure that they achieve this performance and that they achieve it within this budget. If they didn't, then we would go in and review, ask for a performance improvement plan and have the right, in fact, to have the money removed if it continues to be inefficient. So I think bringing them into the LHIN model actually would prevent the problem that you're suggesting could happen.

Ms. Catherine Fife: So you have no concerns of an increased privatization of health care?

Mr. Paul Huras: Well, health care is pretty private in Ontario anyway. It's publicly funded, but the people who deliver it are funded. In long-term care, there certainly is a private sector, as well as the public sector. Again, I believe that the accountability agreements allow us to manage that and manage it appropriately.

The other thing is that I would not want these clinics to be set up without a relationship with the hospital to ensure quality. Because, in many cases, these services could be searchable services, then the quality relationship with the MAC of the local hospital would be important too, and that could be arranged in the same agreement.

Ms. Catherine Fife: Okay. So just to be clear, you're saying that the LHINs would have cost controls placed on these community clinics, as well as quality control and oversight?

Mr. Paul Huras: The quality would be part of the ECFA. Right now we don't have control over quality, but we're trying to improve quality by having system integration, and system integration, we believe, leads to quality. The quality governance, the oversight of the governance, would be achieved by the relationship with the Independent Health Facilities Act with the local hospital.

The Chair (Mr. Ernie Hardeman): Ms. Gélinas.

M^{me} France Gélinas: Thank you for coming to Queen's Park.

My first question is kind of—you open by saying, “To begin: With a significant decrease in bureaucracy....” Where does this statement come from?

Mr. Paul Huras: The fact that in the previous system, with district health councils and regional offices of the ministry, it was a true bureaucracy, because neither of those two organizations, which were two layers totalling 16 DHCs and seven regional offices—23 organizations, more staff than what the LHINs currently have, but also, more importantly, it was a reporting relationship. No one made a decision until it was in Toronto. So there were layers of bureaucracy. Decisions are made at the LHIN, so in fact, bureaucracy has decreased.

M^{me} France Gélinas: We are about to embark on a visit to different communities. Some of them have already reached out to us, and one of the things we hear often regarding bureaucracy—we'll take home care—is that the ministry transfers money to the LHINs, the

LHINs transfer money to the community care access centre, the community care access centre transfers money to a home care provider, the home care provider often subcontracts to a number of different providers, and then those people pay the PSW barely above minimum wage. This could also be seen as a bureaucracy. How would you counter that?

Mr. Paul Huras: The CCAC we see as a provider. They do provide some direct services, and they do contract for their home care services. The hospital actually contracts with the physicians in a way—I'll put quotations around that, “with their physicians”—to provide surgery. They use that facility, but they also provide surgery, and the surgeons are not employees of the hospital. So there is a type of a contracting relationship. We see the hospital as a service provider. We see the CCAC as a provider.

“Bureaucracy” is sometimes used as a bad word, and sometimes it needs to be seen as a good word. Bureaucracy is similar to management in the private sector, and you do need some degree of management—the four roles of management: planning, organizing, controlling and monitoring. You need that in any type of system, including the health care system. So there will always be some degree of bureaucracy. We should constantly be looking at the size of bureaucracy and if we can run organizations and systems more effectively and efficiently with less bureaucracy. That should be a constant look that we always take.

What I'm saying is that the LHINs have decreased bureaucracy in Ontario's health care system.

M^{me} France Gélinas: And you base that on the number of staff on the payroll, you base that on—

Mr. Paul Huras: The number of staff, the number of levels and specifically the fact that DHCs could not make decisions, regional offices could not make decisions, and it had to go to Toronto to make decisions. That certainly was a bureaucratic process. LHINs make a huge number of decisions before we need to go to the ministry for specific decisions. So, yes, I would say it in fact has decreased bureaucracy.

M^{me} France Gélinas: I was a little bit surprised by the comments you made regarding changing boundaries. You basically saw it as a capital waste of time. How do you balance that with people who feel that they would be better served if the services that they reach out to are part of a single LHIN rather than five different LHINs?

Mr. Paul Huras: It depends, again, on which service it is, because you can draw what may be close to an ideal boundary for cardiovascular surgery, but it's not the ideal boundary for some other type of program. The search for the ideal, the perfect boundary, is elusive. You can fuss and fuss or you can make sure that you work around those problems.

Yes, they do create problems. I believe one of the members is from the Champlain area, and Champlain and the South East have a number of boundary issues that we are trying to work through; in fact, one of our health links covers providers in the Champlain area, and the two LHINs have worked on that.

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There should be ways that we can work through those boundaries. I appreciate that, for some people, that is a problem. We need to recognize that and see the best way to deal with it.

M^{me} France Gélinas: If I look on a continuum, you see fussing about boundary change as a capital waste of time, but there could be some little gains. You thought we got it right on the first time with the 14 LHINs, the way we have it now?

Mr. Paul Huras: No, I'm saying that no boundary is perfect. You can spend a lot of time trying to get perfection in boundaries and never achieve it. ICES is one of the most astute system research bodies in the country, and it was their conclusion. But once you settle on it, you need to focus on the things that will really drive improvement to patient care. I think that distracts the focus on improving patient care.

Again, what we've been told from the west, especially regional health authorities in Manitoba, Saskatchewan and British Columbia, is that when they spend time and they actually change boundaries, the words given to me have been, "We throw the system into chaos for a couple of years, and then it settles down again."

I don't think we need that. I think what we need are ways to improve the delivery of health care to our patients.

M^{me} France Gélinas: I'm on page 6 of the version that we have, and another thing that surprised me is that you talked about the 15-minute-long survey that people fill out at 2 o'clock in the morning and how it matched the demographics. What demographics were you looking at?

Mr. Paul Huras: We're looking at basically age structure, so we're looking at the age-sex structure, and it was similar. We did not go in and ask for details on economics, income etc. But on age and sex, it seemed to be a very close match.

M^{me} France Gélinas: Age and sex of the people in your LHIN area, or age and sex of the people who use the health care system?

Mr. Paul Huras: This was to the public, the general public, and this was specifically related to—we did this twice for our clinical services road map and once with our integrated health services plan.

M^{me} France Gélinas: All right. So you have to share your secret with us. The biggest users of health services are usually not the most computer-savvy, so how did you overcome that barrier?

Mr. Paul Huras: We advertised, advertised and advertised about the survey, and we made sure people were aware. We also told them that they could go to libraries and use computers there, and they could come into our office too. They could come into the office and pick up a hard copy if they wanted, or come into our office and use our computer.

M^{me} France Gélinas: How many hard copies did you get, would you say?

Mr. Paul Huras: I'm guessing 7%.

M^{me} France Gélinas: All right. Let's go into the reform that you are looking at, the first one being with primary care. Same question as I asked your colleague before you: What would you see included into primary care for which the LHINs would have responsibility, aside from the community health centres that are already there?

Mr. Paul Huras: There are thousands of primary care entities in this province, and they don't work in a system, and they have difficulty, and they have had difficulty, working with other providers.

Many of these entities—whether they're family health teams, family health organizations, nurse-practitioner-led clinics—in addition to physician compensation, they have additional money. They have money for nurse practitioners, diabetes educators, youth counsellors, but they don't all have the same distribution of that. So some patients may be able to access a primary care provider that has a nurse practitioner, and some patients may not.

If we had primary care accountable for that portion of the money, then we could ensure that they were accountable for being part of the system, for being part of improving access to care, for ensuring that we had 24-hour—maybe not 24-hour, but 18-hour—practice open so that we could have same-day appointments.

When we were building the health links, I had doctors come up to me and say, "Paul, how soon is this going to happen?"

I said, "Well, we need to wait a bit because it's becoming a provincial approach."

They said, "Well, we think we can offer Saturday and Sunday access."

I said, "Go on, no one is talking about that."

And he said, "Well, we can do it. With that many physicians together, we can make an agreement that we will provide that coverage. That would mean being on call maybe once every two months with that many physicians. The thing is, we can build that into an accountability agreement and thereby get more out of primary care."

So it's not physician remuneration; it's about this other amount of money that's available, and we need to hold primary care accountable for that money.

M^{me} France Gélinas: What do you do with fee-for-service physicians?

Mr. Paul Huras: There are fewer and fewer solo practice fee-for-service physicians, and what we did with all our family health teams—as you know, family health teams are not accountable. In the South East, I can tell you what we did with the family health teams. We went to them and said, "Look, we have accountability agreements with community health centres, but we don't have accountability agreements with you. Accountability agreements certainly are about looking at how well you are achieving targets, but it's also about alignment. It's about alignment with priorities etc. That should be of value to you. If we don't have an accountability agreement, how interested would you be in signing a memorandum of understanding?"

And they were; 10 of the 15 signed a memorandum of understanding because they wanted that aligned. We could work with them, even the solo practitioners, and sign memorandums of understanding until such time that we're able to see funding go into these providers.

The other advantage of accountability agreements with primary care—and I apologize for going on—is that we can invest, then, in their organization. We can't invest in any health service provider that doesn't have an accountability agreement. If primary care had an accountability agreement with us, we would be able to invest in it.

M^{me} France Gélinas: What I'm hearing you say—let's say we take the typical FHT. The accountability agreement is for the part—the ministry does not include the part that pays physicians. Are you telling me that what you're looking at is for the accountability agreement only for the part of the FHT that is anything but physicians, that is the other part of the interdisciplinary care, or do you see yourself receiving money from OHIP and then transferring it to the FHT?

Mr. Paul Huras: No, we don't see that. In community health centres, that does happen indirectly because the physician is on salary, but you wouldn't need to do that for the fee-for-service solo practitioner.

M^{me} France Gélinas: No, I mean within a family health team.

Mr. Paul Huras: Within a FHT, you wouldn't need to do that. That money could still be the OHIP money, but the other is a fair amount of money that does allow you to hold the provider accountable for that money and for ensuring that they're focusing on the goals of the LHIN and their priorities.

M^{me} France Gélinas: So the biggest human resource in primary care is physicians, but you would continue to not fund the physician part of the family health teams, family health organizations—FHT, FHO, FHG and all the rest of them, the alphabet soup?

Mr. Paul Huras: Whether it actually would be extremely valuable to do that—I don't believe there's any regional health authority that actually has that responsibility, that actually allocates the physician reimbursement. There are many difficulties with that, in working with the OMA and sorting that out. That could be a long discussion and could be a valuable discussion, but we could act quickly with the other part. You could actually achieve accountability for primary care with the other part and have significant results.

M^{me} France Gélinas: I agree, but you're missing the biggest part.

I want to go before I run out of time because this happened to me last time. The French-language services entities, some of them, are not too happy with their relationship with the LHINs, where they feel, "Why have we got a system where a majority gets to have a veto about what a minority wants and has brought forward?" So at the system level, the LHINs are majority English and they get to veto what the French-language services entity brings forward. Any comments as to the structure of that?

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Mr. Paul Huras: In the South East area, we were the last LHIN to have a designated community. When the LHIN started, we did not have a designated community. I think all other LHINs did.

We've been developing that relationship and I think we're developing it in a positive way. It probably isn't as fast as the French-language community would like it, but it is positive and we have a joint action plan. We're progressing and we report on success with that.

I think it's a challenge for all LHINs to make sure that we're meeting the needs of every group. There is a French language act and we often hear people say, "Well, there are greater populations of other groups than the French," and I say, "That doesn't matter. This is an act. We have to respect the act and we have to help the French language. This is part of our heritage." So we do work on that and I think most LHINs do that. It is a challenge because the requirements can be perceived as beyond what is really the expectation.

I don't think the French community in our area expects there to be a French hospital. I don't think the French community in our LHIN expects there to be totally French services. What they expect is that when they come in, they have the opportunity to go back to their mother tongue immediately and that there is a capability to do that, and we're working towards that.

I'm not answering your question, but I'm telling you that in the South East, I believe that we're trying very hard to meet the needs of the French-language community.

M^{me} France Gélinas: I'll agree that you didn't answer my question.

The Chair (Mr. Ernie Hardeman): Thank you very much for the question and for the answer you did give, even though they don't match; we can't do anything about that.

We will go to the government side. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair. I think maybe my colleagues will have some questions as well.

Mr. Huras, you were for many years with the Thames Valley District Health Council, I believe. If you were to say what was the most important thing, in your opinion, that the shift to LHINs has meant for patient care, could you sort of in one sentence convince us that moving from regional offices and district health councils to LHINs—what is the key difference that that's made for patient care?

Mr. Paul Huras: We are much, much more nimble. We are able to move very quickly on making decisions. The DHCs did wonderful work in every part of this province, some in some clinical areas, others in other clinical areas, but every DHC could tell you great stories. But all that great work often led to two years of waiting for a decision, and people's lives and health care were affected by that.

In the LHIN, we were looking at long wait times in the South East, for example, for orthopaedic surgery—very long wait times. We were the third worst in the province,

if not second worst in the province. We looked at ways that we could improve that, including developing a short-stay unit at Hotel Dieu. We were able to turn that around within half a year, and you saw immediate response. We are much more nimble. LHINs are a true devolution. We are achieving results and it's quite gratifying.

I enjoyed my time with the DHC. I learned a lot, worked with some great providers. This is more satisfying.

Ms. Helena Jaczek: So when you say more nimble and quicker decision-making, that's because it's done at the local level, as opposed to waiting for Queen's Park to weigh in?

Mr. Paul Huras: We're not seeking recommendation. We're very aligned. We're not off on our own, doing whatever we want to do. We're aligned with the ministry. We understand the ministry's vision, we understand the ministry's priorities and we work in our area to identify the local uniqueness of our providers and, more importantly, of our patients. That does allow us to really understand the issue and move quickly on decisions.

Ms. Helena Jaczek: In relation to your presentation, you detailed a particular successful program. I guess that's the other piece that we want to hear: What is being done because the LHIN was there that might not have been done before?

You made reference to the SMILE program. Could you maybe tell us a little bit more about that, what it's doing for patient care and why the LHIN was required to make that happen?

Mr. Paul Huras: The ministry identified aging at home funding available, and it was, how do we allocate this money? The purpose is to keep people safe and comfortable at home and to give their families and themselves confidence that they could stay at home.

We could have asked all providers that currently existed to give us a proposal. Instead, we went to seniors and said to them, "What would keep comfortable? What would keep you confident to stay at home? What would your families need to reassure them that you are safe at home?" They gave us this idea, so we built it. It was unique, it was different. We weren't too sure—and we ended up with them calling it SMILE, Seniors Managing Independent Living Easily. It's the use of money for the purpose of keeping them at home.

I'll give an example: a woman living out in the country who can't afford or is struggling with heating bills and uses wood to heat her home. The children say, "Mum's got to go to an emergency department, has got to get into a long-term-care home. We're not having her slip on the sidewalk or the country path to get to the wood. We're not having this. We've got to get her in a home." She's relatively healthy. She's receiving care from the CCAC, so things are pretty good for her, but that service isn't available. We can make money available to someone down the concession road who would come in and bring wood into her home. It's what aging at home money was about, and that's how we're using it.

There are people who get Meals on Wheels, but Meals on Wheels comes at a certain time. There are some ethnic

groups who don't eat at 12 noon; they eat at 2 o'clock. This allows a neighbour who has a similar type of ethnic background to provide that.

We did an evaluation, and we actually found that it was improving the life for the patient at home and actually preventing them from visiting the ER and ending up in acute care. Also, it delayed their admission to a long-term-care home.

Interruption.

Ms. Helena Jaczek: Don't worry about the bells you'll get used to it.

Mr. Paul Huras: Thanks.

Ms. Helena Jaczek: Keep going; we're at 24 minutes.

In terms of that program, was that administered through the CCAC?

Mr. Paul Huras: No. The CCAC had an opportunity to take that on. We explained the program. We asked providers to submit on it and actually have the VON delivering that care directly.

Ms. Helena Jaczek: I see. So it was sort of a separate accountability agreement, then, with—

Mr. Paul Huras: We already had an accountability agreement with VON. It had to be one of the providers that we had an accountability agreement with, but it was a different role for them.

Ms. Helena Jaczek: Approximately how many seniors have been part of this SMILE program? I sort of want to get a sense of the size of it.

Mr. Paul Huras: I think it's close to 500.

Ms. Helena Jaczek: I see. Okay.

We've seen some of your recommendations, and obviously they're very similar to Ms. Orridge's, which is not surprising. My colleagues have gone into the primary care issue, which I called bold before; I now call it ambitious, as I think about it. You're not aware of any other province that has expanded the role of the regional health authority like this, correct?

Mr. Paul Huras: No, sorry, a misunderstanding: I was saying that the LHIN didn't need the accountability for the physician compensation, the direct fee or the money that would go for the fee payment. But in regional health authorities, I don't know of any regional health authority that has the fee for physicians actually in it too—

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Ms. Helena Jaczek: But they have brought physicians in terms of accountability?

Mr. Paul Huras: Yes.

Ms. Helena Jaczek: Which provinces are those?

Mr. Paul Huras: I think all provinces have the full scope of primary care in their regional health authorities—I'm not sure about all of them, but I know a number of them do. Alberta, for example, does; British Columbia does, is my understanding.

Ms. Helena Jaczek: Do you know how they operationalize that? Do they have accountability agreements?

Mr. Paul Huras: I think primary care is part of the authority, but the actual physician reimbursement—I'm getting out of my knowledge now, so I'm speculating.

Ms. Helena Jaczek: Well, it's always interesting to look at the other models, obviously. I mean, no one wants to necessarily reinvent the wheel, so that will be interesting to hear a little bit more about as we go forward.

However, we do know that some regional health authorities have disbanded hospital boards, as an example.

Mr. Paul Huras: Right.

Ms. Helena Jaczek: Now, you're not making any proposal like that. You are essentially saying that the boards of the service providers that you have accountability agreements with—or at least Ms. Orridge was very specific—need to recognize sort of the authority of the LHIN as it relates to system integration. How do you see this working?

Mr. Paul Huras: I'll defer to Joan.

Ms. Helena Jaczek: Is this one for Ms. Fisk? Okay.

Ms. Joan Fisk: It's an interesting question that you have about governance, because hospitals and all our service providers often have a volunteer board, and it is one that has—

The Chair (Mr. Ernie Hardeman): Could we just move your microphone down a little?

Ms. Joan Fisk: Sorry. Can you hear me better now? I'll come a little closer.

Hospitals and other service providers all have volunteer boards. One of the things that we have done in the Waterloo Wellington LHIN over the last two years since I've become the chair is, we've worked with those boards to have them understand what their accountability agreements actually are. Previous to that, I don't believe that they really understood how they fit in the system; so community engagement is very much part of what we do on the governance side of our communities. And it is getting local perspective when we do hear, on the ground, what their issues are and how they feel about what health service providers are required to do.

Ms. Helena Jaczek: In terms of what you need—so you've had a good dialogue and things are working because they now understand your role better, but is there something in the legislation that you would like to see to ensure that that occurs?

Ms. Joan Fisk: I believe it is in the legislation. They do have this written in the guidelines. It was really more about awareness of what really is their role and what is their responsibility in that particular sense—and also getting them to understand that they're part of a system. It's really an important piece of the communication.

Ms. Helena Jaczek: Mr. Huras, do you have something to add?

Mr. Paul Huras: I was just going to say that when LHINs were first developed, I remember someone speaking to the LHINs—the CEOs and the board chairs from a regional health authority, actually—and they said, "You know, with all these boards in place, I don't know how you're ever going to get anything done." I said at the time, "Well, it may take us a bit longer, but by bringing the boards on"—when you think of it, we've got over 100 organizations, at least 10 board members. We've got all this extra social capital available to us. If we get them

on board in making a decision, that's a pretty darn strong decision. It's probably stronger than what regional health authorities can get because anybody can sabotage a decision; but if you get the boards agreeing to this, "Yes, this is the way to go forward," it's very, very strong.

Ms. Helena Jaczek: Okay. Thank you. Now, my board chair for the Central LHIN was kind enough to forward a number of recommendations. One that I was interested in in particular was the role of the health professionals advisory committee, because I believe that is in legislation, that there is a mandatory requirement that a LHIN have such an advisory committee, in essence. In your experience in the South East LHIN, have you found this to be a useful structure, or do you have any recommendations related to it?

Mr. Paul Huras: The structure is useful. We meet every third month, and we do have turnover on it because people are moving to other parts of the province.

But it's advice. Their responsibility is to give the CEO advice that influences decisions. We will speak to them about priorities, about developments, about plans, and get their feedback about how we should look at this from an interdisciplinary perspective, a health professions interdisciplinary approach, and also any advice they would have for us about how to work with the health professions on this particular issue.

I still think we're all sorting out the role of HPAC. The role probably varies in each LHIN, and some LHINs have it meet more often than not. It is an area to be reviewed, I think, and to really look into the value. We have seen value, but I'm not sure if there's not more value that we could obtain from this group.

Ms. Helena Jaczek: How are the members recruited, or how are they chosen, to be on that particular advisory committee?

Mr. Paul Huras: We advertise, but we also shake the bushes, from people who we know in the industry or in those professions, to identify others who might be interested in serving in this role. We interview them and explain to them. We'll invite those who are interested to come and observe a meeting, and then they'll help decide whether or not this would be valuable for them.

Ms. Helena Jaczek: As an example, the physicians aren't necessarily the district representatives of the OMA—or someone who, perhaps, has been elected by a body?

Mr. Paul Huras: We heard that interest originally. Our LHIN did not go that way. Yes, we do not have elected representatives.

Now, we do work with some of the elected representatives from the OMA. They have these regional coordinators—I think there are seven of them; so each one has two LHINs that they work with—and we do have discussions with them twice a year, anyway, and those are very valuable discussions. It's not part of HPAC.

Ms. Helena Jaczek: Okay, those are all my questions. Anybody else?

The Chair (Mr. Ernie Hardeman): Mr. Fraser?

Mr. John Fraser: Thank you, Mr. Huras and Ms. Fisk, for coming in today. I do want to comment on your SMILE program. It sounds like something that's the kind of community-based solution that you want to find, that adapts to what local needs are.

I wanted to ask you, just to follow up on the previous presenter, you do have open board meetings?

Mr. Paul Huras: Yes, we do.

Mr. John Fraser: You do. And do you travel as well, too, across your catchment area or do you do it just—

Mr. Paul Huras: We've done that every year except this year, and we're evaluating whether to continue to do that. In some of our communities, we were able to set up the meetings nicely, with contact with a radio station—we might have a pre-interview with our board chair before the meeting—but we still never got a large turnout.

Some of these areas are pretty small. I mean, we're one of the smaller populations. We have 500,000 people and a large geography; we're one of the most rural of any of the southern LHINs. But we never had a huge turnout, so we're looking at that. We probably will state it, but I think it's more related to our communications effort. But people are interested in their hospital very much.

Mr. John Fraser: I've seen the difference in hospitals in an urban area and in a rural area. There's a great affinity there, so people are very connected to it.

How do you manage, from a community perspective, having such a large geography and having such a rural population?

Mr. Paul Huras: We make sure we visit those places. We are there; we're talking to people. We've done a lot of meeting with chambers of commerce and Rotary clubs. We think it's very important.

Health care is very emotional to the general public. Laparoscopic surgery is a great example. If you were a health planner, you would take how long it took to take out your gall bladder—the length of stay was usually seven to 10 days—you multiply that by the age/sex need for gall bladders, you adjust for occupancy, and you come up with a number of beds. All of a sudden, someone comes along and develops a laparoscopic surgery—much better care for the patient, but it also takes that factor of 10 down to one or two. You do the same calculation, and it comes up that you need less beds. You close the beds, and the public gets very upset about that.

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We talked to business people. We've explained the pressures of the economy and the pressures of the fact that there's a new patient. We say to the business people, "You need to help us and your local health care providers in explaining this need to the general public," and they get it. They understand that there needs to be transformation and change. Change is scary to the general public. We go out and we talk to everyone who will listen. We get out there. It's a lot of driving, but it's very important, and you learn so much.

We had an engagement session in a rural area, a very rural area—so rural, six people came out, and they said to

us, "If we had known a little earlier, the other six people wouldn't have gone to choir practice tonight." It was that type—but we met in this group a homeless person. I know of homelessness in cities; I didn't know of homelessness in rural communities. It was shocking.

We learn so much from those experiences. Sometimes, they're tough on us, but that's okay. Sometimes they give us great insight.

Mr. John Fraser: That's great. I want to ask you a bit about boundaries, because we were talking about that a bit earlier. Again, my experience is that we have very few boundary issues in Champlain LHIN. We obviously have a connection with you. Who else do you have a connection with?

Mr. Paul Huras: Central East—it's actually North East; a little part of us is linked to North East. The biggest issue that we have with Champlain, that we worked very well with, was the leftover from the Health Services Restructuring Commission, the divestment of the Royal Ottawa services that were in Brockville to the South East LHIN.

Mr. John Fraser: I know that was a particularly difficult one, because it was a major transformation.

Mr. Paul Huras: But by working together, the LHIN and the two hospitals solved it. We solved it in a great way, a way that met the needs of the patient. I think we're all proud of that.

Mr. John Fraser: I guess just to the remarks, I understand what you're saying: Boundary changes aren't going to solve things. But just as a piece of advice, if you're in a LHIN where more than 50% of your business is in a boundary, that presents a certain kind of challenge. What advice can you give to somebody who's in that particular situation?

Mr. Paul Huras: I think it's fine to look at them and just be very, very careful of being cavalier in thinking that you're creating the perfect boundary. If your goal is to create the perfect boundary, my argument is that you won't. But if there is a mistake there, if there are some opportunities to change them for the better, then we should be looking at that. I just say we do it with caution and be very respectful of the implications.

Mr. John Fraser: Thank you very much.

Mr. Paul Huras: Thank you.

The Chair (Mr. Ernie Hardeman): We'll go to the official opposition.

Mrs. Jane McKenna: Thank you so much for coming in with your presentation. My first question is, when you say that you're out driving around all these places, what do you do with the information that you get?

Mr. Paul Huras: As I said, I think we have a very sophisticated quantitative analysis. We always put the quantitative analysis into context with the information that we receive from engagement. It grounds the data. I'm an epidemiologist by training. I believe it's important, once you've done the analysis, to step back and say, "Does this make sense?" By communicating and engaging communities, you're able to do that.

I could give you an example; I'd love to tell this story. We'll have a family member who will phone us and say, "I've got a problem. This has happened; this has happened. My mother has this problem," etc. It's a single patient, and we're not at that level. It would be so easy to say, "We're a system planner and a system manager; we don't really deal with an individual patient," but that's bureaucratic ho-hum that doesn't do any good. So we ask them, "Can you help us understand how the system has failed?" By them explaining it, then we can work with the provider to change the system.

We have examples where this has happened. What we did was, we brought in all the players that potentially could touch this patient, and we had them solve the problem. It was really interesting: All these visible leaders around the room watched as some of the non-visible leaders actually solved the problem. The thing was, they did solve the problem by speaking with each other.

So what the LHIN provided was this opportunity to listen to the problem and turn it into a system issue, which actually improved the life of this patient, the life of this family, but it also ended up with us changing the system so that future patients would have benefitted from the solution.

Mrs. Jane McKenna: Okay. I'm going to ask you again, because I didn't get an answer from you.

Mr. Paul Huras: Sorry.

Mrs. Jane McKenna: Again, what do you do with the data that you go out and drive around all these miles? What do you do—

Mr. Paul Huras: We use that to help make our decisions, but listening to data or listening to input doesn't mean we do everything we're told. If we did that, we would be changing things constantly. As many people tell us one thing, we have people telling us another thing. Listening and engaging does not negate our responsibility to make a decision. We use that information to help put the data in context, and it helps us understand the system and it often helps us make the changes that are good for the system.

Mrs. Jane McKenna: You just said a statement back a bit, a couple of minutes ago, about patients and it's not all about the patients. But as a system manager, don't you measure your success by how your patients are doing?

Mr. Paul Huras: Absolutely.

Mrs. Jane McKenna: Wouldn't that be your number one focal point?

Mr. Paul Huras: Absolutely. But what I'm saying is that some patients will tell us one thing and some patients will tell us the exact opposite.

Mrs. Jane McKenna: I think they're all going to tell you the same thing: how the system was that they went through. Regardless if it was rural or urban, everybody is going through a system that is set up by not a service provider; that you facilitate that as a system manager and if they're not getting through the system properly, there's an issue.

Mr. Paul Huras: Yes. Where that's a common issue, we act on it.

Mrs. Jane McKenna: I agree with Ms. Jaczek when she's saying you only have so many people coming to your office and clearly you're not having all the people come, but I can pretty much say that all of the—the MPPs I've spoken to all have the same similar problem with what we're saying, that the system's fragmented. You're not speaking from one LHIN to the next. The people who have great information are not passing that along and for the eight years, seven years, however long you want to say, there's a lot to be fixed. So—

Mr. Paul Huras: And there's been a lot that has been fixed, yes. You're absolutely right.

Mrs. Jane McKenna: I guess I'd like to see what those things are that you have fixed somewhere, because it just seems that one thing doesn't add up to the next.

My next question to you is, this SMILE program that you have, where do you get the money for that because in Burlington—

Mr. Paul Huras: Aging at Home funding.

Mrs. Jane McKenna: Excuse me?

Mr. Paul Huras: Aging at Home. It was a provincial allocation of money identified as Aging at Home funding.

Mrs. Jane McKenna: Okay. Because in Burlington, and I know other places say the same thing, it's hard enough just to get the basic nursing services for our people who are coming to us. I'm not sure, when you have other things, like Meals on Wheels and all these other things that you have, where that money's coming from in the sense that we're struggling in Burlington with just the basic services for nursing.

I guess my question again is, if you have that money allocated for there, why isn't it allocated for just basic nursing services and other—

Mr. Paul Huras: We've been investing in basic nursing services also.

The Chair (Mr. Ernie Hardeman): If I could just stop there, we have a vote. I have to adjourn the committee for the vote. Hopefully, if the delegates would just wait till we get back, and we ask all the committee members to come back as quickly after the vote as possible so we can conclude.

The committee recessed from 1739 to 1748.

The Chair (Mr. Ernie Hardeman): The committee will come back to order. Thank you all for your indulgence.

With that, we'll turn it back over to the official opposition. Ms. McKenna.

Mrs. Jane McKenna: As I was walking down to vote, I was thinking: You talked about how you were shocked, after eight years of having this position, about rural homelessness. Did you not ever think at any time that there was homelessness everywhere? It's a systemic problem, whether it's urban or rural.

Mr. Paul Huras: This wasn't after eight years. This was the second year into the LHIN development that I saw this. I had not seen homelessness, and I don't think

I'm that unusual; maybe I am. Homelessness is what you see—you don't see homelessness in rural communities unless you're living there.

This individual lived in a shack on the property of somebody else who just ignored it. But the point that he was making was that he didn't have an address; therefore, he didn't have OHIP, and therefore he couldn't get health services. We tried to figure out ways that we could address that.

Mrs. Jane McKenna: Okay, my next point here is that on page 10 here in the summary, you say, "In fact, I have been told by regional health authority CEOs that it is time for them to start paying more attention to LHINs as they are achieving results that have escaped their grasp." Don't you think they know that without having to be told?

Mr. Paul Huras: I think there probably are a lot of CEOs who look at their own environment and aren't scanning the wider jurisdiction all the time. What they were learning was what we were doing with health links, and they thought that was marvelous. They thought the integration that that was bringing at the sub-region level, the vertical integration that that was achieving—they were very, very impressed with it. They said, "We're not achieving this in our areas. We're not achieving that linkage of primary care with others."

Mrs. Jane McKenna: Then on page 7, health services funding formula, who came up with that funding formula?

Mr. Paul Huras: That's a provincial funding formula.

Mrs. Jane McKenna: You have on page 6, then, "I believe that engagement has resulted in better decision-making about service adjustments, improvement, development and funding." How is that? How have they resulted in better decision-making about that?

Mr. Paul Huras: SMILE is a good example. We engaged a lot with primary care physicians from day one, and that has helped us develop this relationship with primary care in the South East. That has had a tremendous input with the actual success we've had with health links. With patients and the general public, with our clinical services roadmap, we've been able to influence our clinicians, who are developing these plans regarding seven clinical areas, and the input of the patient and the patient experience is actually changing the way they're thinking.

Mrs. Christine Elliott: I'd like to thank you both for coming here today and sharing your thoughts with us. I have three questions, which hopefully I'll be able to get in in the time allowed, because we're rapidly running out of time.

My first question deals with the quality issues that you noted on page 7 of your report. You indicated that "generally, people are not pleased with the quality they receive from the system," and they referenced the "lack of medication reconciliation, lack of timely test results, having to repeat their 'story.'"

To me, a lot of that looks like it might be attributable to a lack of electronic medical records, but perhaps you could share with us what your perspective is on that.

Mr. Paul Huras: That's an enabler. Certainly, electronic medical records are a big enabler in health links. We are addressing that. The seven health links have all agreed to a common approach to electronic medical records and the exchange of information. That should enable them, but you still have to get the providers committed to working equally together, not a hierarchy of providers but providers actually working together equally to say, "This is a complex patient. This patient needs this, this and this. How do we do this?"

I don't want a hospital CEO to say, "We've got ALC patients. This is your problem. Get them out of our hospital." We need them working together and finding the way to do this. That's what we're achieving from this. These organizations now are recognizing that together they have an equal role in solving the problems of complex patients, these patients who need all these different components of care. When the system lets them down, it can go bad for the patient very quickly. We're trying to really address that, focus that and turn that around. I think we're starting to make some success.

Mrs. Christine Elliott: But certainly, the lack of progress on this file continues to be a problem in the system.

Mr. Paul Huras: The e-health file specifically, you mean?

Mrs. Christine Elliott: Yes.

Mr. Paul Huras: Yes, but again, there are successes across the province. In the South East, the fact that seven hospitals have agreed to a common platform is big. That's very expensive. One hospital had already made a decision to start going down the road of replacing their system, but as soon as we got to the point where there was agreement about one system, they pulled back and are going to go in a different direction. We will have one platform for the hospitals. Again, the seven health links that we have—it's tremendous that we are going to have a single approach to e-health or enabling technologies for that group too.

Regardless of any problems in the past—Canada has been slow with e-health, but speed is picking up now and we're starting to see it really take off, certainly in the South East and I know in other LHINs too.

Mrs. Christine Elliott: Thank you. My next question relates to the independent health facilities and your comments on page 9 that they need to be accountable to the LHINs. I'm just wondering what you would recommend in that respect. How do they need to be accountable and what are you recommending?

Mr. Paul Huras: I mean that they should be signing service accountability agreements with us, and in those agreements we would put performance indicators and targets. Then, for the funding they would receive, they would achieve those targets.

Every time we send out a funding letter, we put in what is expected for that funding. That didn't use to happen in health care. We've spent billions and billions of dollars in health care in the past, and you could tell you had this many doctors or this many nurses, but you couldn't tell much more than that.

Right now, every time that we send out a dollar, we say, "This is what we expect for it." We'd be able to do that with the independent health facilities and then that really creates them being a part of the system. It would help ensure that we're not just creating—and they exist today, but they wouldn't be outside the system. They'd be in the system in many, many more ways, and we would have this ability to say, "You're not meeting your targets" or "You are meeting your targets." If they're meeting their targets, then we could invest further in them in the future.

Mrs. Christine Elliott: So that would be primarily just by virtue of the contractual arrangement, rather than anything else. Is that correct?

Mr. Paul Huras: The contractual arrangement also identifies very clearly this alignment that I talked about, where they're connected to provincial and regional priorities and they understand those and what is their contribution.

Mrs. Christine Elliott: My final question relates to the wait times issue. You may have been here when I was speaking with Ms. Orridge about the optimization of data issue. Can you tell me if that has been something that you have been dealing with in either one of your LHINs? Has any kind of directive gone out with respect to optimization of data?

Mr. Paul Huras: I heard you ask Camille that. I'm surprised; we are not aware of any of that in Ontario. There are two different pieces of the wait time. There is wait time 1 and wait time 2. One relates from when the referral is made to the specialist and then the procedure is

completed, but there's that other wait time in the front end. To really make movements on targets you have to be able to measure, and the first one is more difficult to measure. The second one is the one that was measured. That's where there was a lot of focus and that's where there have been a lot of gains made.

I have not heard, in our LHIN—and we work with the surgeons as well as the chiefs of staff and the CEOs, and we have not heard them coming to us that there has been pressure to change the reporting. I believe that it's done above board and appropriately, so I was surprised to hear you. I don't know what else I can add to that.

Mrs. Christine Elliott: Thank you very much. Did you want to add something?

Ms. Joan Fisk: Thank you very much, Ms. Elliott. I have never heard that optimization issue, but I do thank you for bringing that forward, because I would look, from a governance point of view, to make sure that the data we do get and the ones we make decisions on are the ones that are legitimate and are measuring the wait times we have in Ontario. Thank you for that.

Mrs. Christine Elliott: Thank you very much.

The Acting Chair (Mrs. Jane McKenna): Thank you so much.

For committee business, we'll do it tomorrow if we have time. For December 9, we're going to have the Association of Ontario Health Centres and also the Ontario Federation of Community Mental Health and Addiction Programs.

We're adjourned.

The committee adjourned at 1759.

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Lundi 9 décembre 2013

Standing Committee on Social Policy

Local Health System
Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur
l'intégration du système
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 9 December 2013

Lundi 9 décembre 2013

*The committee met at 1404 in committee room 1.*LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): We'll call the meeting to order. This is the Standing Committee on Social Policy. This is the December 9 meeting and we're here to review the Local Health System Integration Act and the regulations made under it as provided in section 39 of that act.

ASSOCIATION OF ONTARIO
HEALTH CENTRES

The Chair (Mr. Ernie Hardeman): We have with us the first presentation of the day, the Association of Ontario Health Centres: Adrianna Tetley, executive director of the association. Thank you very much for being here. I think it's a half-hour presentation, but then we turn it over for 20 minutes to each party for questions and comments.

We are presently recessed, but when the party leaders get back into the House, they are going to be making some very important statements. So I expect the committee will recess for that period of time and then come back to hear the rest of our presentation, if that should happen between now and the time your presentation time is over. So we beg your indulgence.

With that, we'll turn the floor over to you.

M^{me} France Gélinas: Chair, can I interrupt for one second?

The Chair (Mr. Ernie Hardeman): Yes.

M^{me} France Gélinas: I think I did it while we were in camera; I asked the researcher if she could give us an update as to what was happening in the rest of Canada and in other jurisdictions. I don't know if I have to do this outside of camera so that it gets done.

The Chair (Mr. Ernie Hardeman): I believe that would likely have gone through the researcher to gather information. We can't make any decisions, but the researcher can be—no, the researcher wasn't here.

Ms. Carrie Hull: No, no, I was here, but she said it off the record, and I just thought the procedure was that you authorize it.

The Chair (Mr. Ernie Hardeman): Oh. Well, that's only if there was some reluctance by legislative research

to produce the information, and then it would require a motion. But as long as we're all aware of that which was requested, we'll put on the record now that that which was requested by the member at the previous meeting be provided—what do they call that?—toute de suite.

Thank you very much, and the floor is yours.

Ms. Adrianna Tetley: Good afternoon, Chair and honourable members of the Standing Committee on Social Policy. My name is Adrianna Tetley, and I am the CEO of the Association of Ontario Health Centres.

As Ontario's voice for community-governed primary health care, the Association of Ontario Health Centres is really pleased to present to the Standing Committee on Social Policy as it begins its review of the Local Health System Integration Act, LHSIA.

The association represents 108 community-governed primary health care agencies across the province: 75 community health centres, 10 aboriginal health access centres, 15 community-governed family health teams and nine nurse-practitioner-led clinics. These centres are distinct from Ontario's other primary care models because they are all governed by community boards. All 75 community health centres are the only primary care model in Ontario that currently falls under the jurisdiction of the LHINs. This allows us to bring a unique perspective to this table.

CHCs are located in each of the province's 14 LHINs. This presentation is largely informed by our experience working with the LHINs over the last seven years. AOHC's submission is also shaped by our vision, a vision that unites our membership: the best possible health and well-being for everyone living in Ontario. Underneath my statement in your paper is a detailed look at what that future would look like. At different points in my presentation, I won't be reading the sub-points; they're there for your reference for later.

Our member centres are actually committed to a leadership role that achieves this vision of community health and well-being. To do so, we have also recently adopted a model of health and well-being to guide our delivery of primary health care. This is important as we go through our comments, and you will find it in the appendix of the brief that you have in front of you.

Our submission provides AOHC's perspective on how the LHINs, at a regional level, can also lead the way towards community health and well-being. First, let me start by saying that the review process offers a critical

opportunity to maximize the LHINs to full potential. Going forward, the LHINs need to play a key role in establishing community health and well-being regional systems that promote the best health and well-being for everyone. To achieve this, we actually urge the committee to consider the following directions for change.

(1) Require the LHINs to use a health equity approach as foundational to all its work.

(2) Enhance the capacity of the LHINs to serve as strong planning bodies across the full continuum of care, especially when it comes to building a more organized and effective primary health care system.

(3) Widen the LHINs' scope. The act defines the objectives of LHINs too narrowly on treating sickness and organizing health services. LHINs should be mandated to prevent more in order to treat less, with a special focus on prevention measures that address the root causes of illness and disease.

(4) Build strong community-based services.

(5) Require the LHINs to improve their processes for meaningful community engagement and responding to the needs of the communities they serve.

These are directional recommendations based on our years of experience working with the LHINs. As the committee continues its review, we're hoping that our membership and you will continue to explore these ideas further. Today I am going to present some more specifics around each of these as we go forward with our conversation.

AOHC actually stands by our 2005 submission to the standing committee when LHSIA was first introduced. At that time, we supported the establishment of the LHINs, and we continue to do so, because we believe it represents a major opportunity to press forward with a positive transformation for health and health care in Ontario.

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Ontario needs regional bodies that understand the regional perspective and unique realities of their communities and are held accountable to the regions they serve. We also need regional bodies equipped to set objectives, evaluate performance, allocate budgets and hold providers accountable for the services they deliver. However, AOHC contends that it's time for the LHINs to be retooled. In our view, the purpose of the LHINs, as currently defined in the act, doesn't capture a big enough picture.

The act opens by stating that the main purpose of the LHINs is to improve the health of people living in Ontario, but reading through the rest of the act and watching what's happening on the ground, it's clear that the LHINs' *raison d'être* is health services integration, especially the structural kind of integration.

Later in my remarks, we will offer our thoughts on building an optimal approach to a more integrated health system, but in our view, integration, especially structural integration, should be treated as just one means to achieve a longer goal.

In our view, the LHINs' long-term goal should be the establishment of community health and well-being systems across the region that promote the best health and well-being, and ensure equitable health outcomes for everyone. This health system must be retooled to deal with the fact that good health is not just something that you get in a medical clinic or a hospital. Promoting a sense of health and well-being requires reaching objectives that are currently not listed in the act.

We have an overall recommendation. The overall recommendation is that the act should be enhanced with the following objectives explicitly stated as purposes in the LHIN:

(1) Advance health equity and reduce health disparities.

(2) Advance upstream interventions that address the root causes of illness; in short, prevent more in order to treat less.

(3) Conduct comprehensive system planning that advances population health with equitable access to services.

(4) Develop a high-performing primary health care system with the capacity to fulfill its role in the foundation of the health system; and

(5) Develop high-performing, community-based services.

To implement this overall objective, the committee has to ask itself: If we are to achieve an integrated community health and well-being system that promotes the best possible health and well-being for everyone, ensures equitable health outcomes for all and ensures a sustainable health care system, what are the changes required in the act to enable the LHINs to achieve this vision and to transform the delivery of health services? In 10 years, what parts of the system will be the same? More importantly, what parts of the system will be different and how do we enable LHINs to have the tools to transform the system? Through my remaining remarks, we will provide principles and recommendations that we believe are essential in achieving this vision.

The first one we want to speak about is equitable health outcomes. Only in the preamble of the act do you find a commitment to equity briefly mentioned. In the main body of the act, the need to advance health equity and reduce health disparity is not explicitly mentioned, yet the provincial government currently describes health equity this way: Within the health system, equity means reducing systemic barriers in access to quality health care for all by addressing the specific health needs of people along the social gradient, including the most health-disadvantaged populations. This is a provincial policy.

In Ontario, the LHINs could just look at some of the facts that we all know. I'm not going to read them for you today, but we do know that aboriginal people, francophones, many people living in poverty, people in the north, South Asians, immigrants and LGBT people all have worse health outcomes than the general population. We believe that the province and the LHINs can do more to advance equitable health outcomes and reduce

health disparities. The ministry has developed a powerful tool called the health equity impact assessment that is specifically designed to identify and mitigate unintended impacts of any health initiative on health outcomes prior to implementation, yet in the minister's action plan, health links, or in any provincial initiative that we're aware of, HEIA is not applied.

Our recommendation in relation to this is that the objects in the act should be expanded to ensure equitable health outcomes and the reduction of health disparities for all people living in Ontario, with a particular focus on the people who are most marginalized.

Number two, the MLPA—the ministry-LHIN performance agreement—should include the requirement that HEIA be used in all regional planning and in the application of all provincial health links.

We want to focus upstream so that we can prevent more and treat less. Effective treatment of illness is critical to the health and well-being of Ontarians, and we continue to support the work that the LHINs are doing in making a more efficient and effective illness system.

But if we want to ensure the health and well-being of everyone in Ontario and sustain our health care system, the LHINs must place a stronger focus on preventing more in order to treat less. The population health and system sustainability will improve if both the province and the LHIN apply a broader, stronger focus on prevention, especially prevention that addresses the broad determinants of health.

As things now stand, Ontario currently applies a downstream as opposed to an upstream approach. We are not doing enough to build systems and supports to deal with all the factors that affect health, not just the medical ones.

When we look at the LHINs' mandate, and I've had several conversations with the LHINs, they are more focused on health care than on health. This is clearly reflected in what LHINs are measuring and not measuring, and funding and not funding.

I heard you in the different Hansards talk about the 14 of the 15 LHIN performance indicators that are currently required by the LHINs. They're all focused on the acute system. One indicator is actually focused on home care. There are no indicators that measure how well LHINs are doing keeping the populations they serve in good health or that measure health equity.

Several HSPs, health service providers, including our members, provide a wide range of upstream services, including assisting with housing, education, employment and food security. Yet the LHINs are not mandated to understand or learn how these services impact the health of the most vulnerable populations. They have not significantly funded these services and have shown little interest in measuring the health outcomes of this work. Health promotion and community development work that address systemic barriers, assist people with the root causes of their ill health and support communities to build capacity and resilience to keep people and

communities well are not well funded and are seen as out of the scope of the LHINs.

Health and well-being indicators must be developed alongside the more clinical indicators. This will help the LHINs to have a more fulsome understanding of how working upstream can continue to improve health and well-being. As well, oftentimes our service providers feel invisible with the LHINs because they don't recognize this part of the work or are not held accountable for the work.

Our recommendations are that the act must be amended to expand the LHINs' purpose and objectives to encompass health promotion and illness prevention, with a strong focus on addressing the broad determinants of health. We believe that health and well-being performance indicators must be developed at the ministry, LHIN and HSP levels through their accountability agreements.

Like HSPs, the LHINs should partner with other regional partners, such as the school and justice system, to collaborate on addressing some of the upstream issues that have a direct impact on the health and well-being of the people in their regions.

Number three is population health planning. Planning needs to take a population-needs-based planning approach, yet we have public health units that have a mandate of population health. There have been significant resources, especially in epidemiology, yet in many areas, the LHINs and public health units work in silos, duplicating and not sharing information. LHINs should be mandated to work with the public health units as co-partners to develop LHIN population-needs-based plans, using a health equity lens that looks 10 years out for trends and that informs regional system plans.

LHINs must also plan specifically for the aboriginal and First Nations and francophone populations. Under the act, the minister is required to establish two councils: an aboriginal and First Nations health council and a French-language health services advisory council. Under regulation, francophone and aboriginal planning entities are also to be established.

There has been no progress on the aboriginal and First Nations health council or planning entities. The French-language health services advisory council meets very sporadically, and the French-language services planning entities are still being operationalized. The French language services planning entities actually sign accountability agreements with the LHINs, which questions their ability to make plans if they are reporting to the LHIN through an accountability agreement.

Given that the first peoples communities and the francophone population have distinct and specific histories, and legal and constitutionally protected rights, these advisory councils and planning entities need to be established to ensure respect, inclusivity and equity.

Given the poor health outcomes of these two populations, the minister, through the advisory councils, must make it a priority to develop a provincial first peoples and a provincial francophone health plan that is culturally safe, competent and appropriate. The regional planning

entities then need to be empowered to work in partnership with the LHINs to implement these plans at a regional level. As such, the accountability to report to the LHINs needs to be reviewed.

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Our recommendations are that:

(1) The act should be amended to incorporate the requirement for the LHINs and the public health units to form an equal partnership to develop LHIN-based population needs with a health equity lens.

(2) The aboriginal and First Nations health council and planning entities regulation must be implemented.

(3) The ministry needs to work with the aboriginal and First Nations council and the francophone council to establish culturally appropriate health care plans. Primary health care should be considered a priority.

(4) The reporting mechanisms of aboriginal, First Nations and the francophone planning entities reporting through the accountability agreement to the LHIN need to be reviewed in order to ensure the planning entities can fulfill their full mandate.

Principle number four is comprehensive system planning across the full continuum of care. To create integrated community health and well-being, comprehensive system planning is required. LHINs should be the planners for the full continuum of health services, equipped with the authority, accountability and resources to do an effective job.

Hospitals should not drive regional health planning. If they do, the system will continue to be focused on illness and the shift to health promotion and disease prevention will not occur.

To ensure a more seamless system, LHINs should plan for a person's journey in and out of various parts of the health system throughout their lifespan. To do this, they need to be responsible to plan and coordinate the entire continuum of care. This will ensure transitions for people moving through the health system, as well as more efficient use of resources and skills, fewer errors and improved experience for the people accessing services and their caregivers.

To enable this, all remaining direct service programs at the ministry should be transferred to the LHINs, including HIV/AIDS, the underserved area program and hep C, among others.

If some part of the health system is not under the jurisdiction of the LHINs, they need to collaborate to ensure integrated and coordinated services are provided. A good example of this is EMS, the emergency services of the municipalities. We can't just say that they're not under the authority; they need to figure out a way to collaborate in order to plan.

There is increasing agreement that primary care is the foundation of the health care system. It should be a key door where individuals intersect with the health system through various points in their life journey, yet primary care is the most fragmented, siloed, provider-centric part of the health system.

The LHINs have stated they want primary care to be accountable to the LHINs. I would go further. The LHINs need to be responsible for planning primary care, not just holding them accountable once the providers themselves, or the ministry, have decided who goes where. Gone are the days when a solo physician or a nurse practitioner should be able to open an office where they please.

In the South East LHIN, in partnership with their public health unit, the LHIN conducted a study to measure the deprivation of a community and then mapped it against the current primary care provider supply. The results were predictable. The areas with the highest material and social deprivation—i.e., the poorest communities—had the least access to physicians, and the more well-to-do areas had an oversupply of physicians.

In another rural area, seven physicians are all over the age of 65 and several are over the age of 75, all with large numbers of enrolled patients. What is the transition plan? Who is responsible? Should they be replaced with seven physicians or with an interprofessional team of some mix of physicians, nurse practitioners, dietitians and social workers? Who will make this decision?

In addition, like everything else, primary care models need to be developed to meet the needs of the community. This means that a mix of primary care models that are designed to meet the diverse needs of the communities, and that are evidence-based, should be implemented.

Finally, primary care planning conducted by the LHINs should build towards an ultimate goal that all Ontarians have access to interprofessional teams. This would involve developing a transition strategy that is incremental and is developed taking into consideration retiring or moving physicians, new grads or, by choice, by existing physicians who want to migrate from fee-for-service into teams.

So our recommendations are that:

(1) The ministry should transfer the remaining provincial programs that provide direct services to the LHINs.

(2) The act should be amended to include interprofessional primary health care organizations as health service providers.

(3) The objects in the act should be amended to mandate the LHINs to plan and implement a primary health care delivery system that is population-needs-based, is evidence-informed and ensures an appropriate mix of models to meet the diverse needs of communities.

(4) In the MLPA, a mechanism should be outlined to develop a transition strategy to enable interprofessional primary health care organizations to be the models of the future.

This leads us nicely to principle number five: high-performing primary health care. A strong primary health care system, as we have said today and in other places, must serve as the foundation of the health care system to keep people healthy and out of hospitals. We believe that there are several key elements of a high-performing

primary health care system. We will only focus on a few today that are under the jurisdiction of the LHINs.

As stated earlier in my remarks, we believe that interprofessional primary health care teams should be the model of the future. We also believe that in an efficient and effective high-performing primary health care system, all members of the team should work to their full scope of practice. This will not only ensure continuity of care with integrated and coordinated care for the people we serve, it will be more efficient and sustainable for the health care system.

As a high-performing system, we believe that all primary health care organizations should provide system navigation and care coordination for the people they serve, including as they transition in and out of other parts of the health care, community and social service systems, throughout their lifespans.

Our recommendation is that the LHINs fund and support the interprofessional primary health care teams to be appropriately resourced to enable all members to work to their full scope; and to ensure that interprofessional primary health care organizations are resourced to provide system navigation and care coordination as people navigate in and out of the health care and social service system throughout their lifespan.

Number six: Champion a culture of system navigation. The sustainability of Ontario's health system depends on the ability to keep Ontarians healthy and avoid the need for costly care. A high-performing, community-based sector is another foundational piece to achieve this goal.

AOHC envisions strong community-based services that address the determinants of health and that are integrated, coordinated and efficient, working in partnership with the long-term care and acute care systems.

More specifically, primary health care, not-for-profit home and community support services, and mental health and addictions services, the key players in the community sector, must work in partnership with other parts of the health system to create a comprehensive, fully integrated and seamless system where people can access the right services at the right time by the right provider.

The history of—the community support services have often been filled by volunteers who have grown over the years, and as a result we have many large and small organizations—many of them are underfunded—who are the life of the organization, relying on countless hours of volunteer time. Services are often front-line, community-based, consumer-driven and client-centred.

We endorse a system where every door leads to appropriate and effective services that are people-centred and coordinated at the local level. This requires a province-wide culture of service integration across health sectors and providers, championed by the ministry and the LHIN. The true test of any integration initiative is whether or not it enhances the care, improves health outcomes and results in improved quality of care for the person.

AOHC, along with the association for mental health in Ontario and the Ontario Community Support Associa-

tion, supports integration initiatives that reflect well-researched best practices. There's a significant number of well-researched criteria that drive good practices and that are listed there for you for a future read.

A primary role of the LHIN is to promote the integration of the LHIN system to provide appropriate, coordinated, effective and efficient health services. As we all know, the act identifies five strategies, ranging from coordination and partnership to amalgamating services and cessation of operations. The LHINs' current work on integration seems to be focused on structural integration—back office and reducing the number of HSPs—and does not necessarily lead to better service.

In fact, recently one service provider presented a new service integration to the LHIN. There were no cost savings, but there was improved and more coordinated care. The LHIN response was: "That's fine for year one, but in year two I expect financial savings."

In another LHIN, for the past three years, there has been an attempt to merge all the mental health agencies into one LHIN-wide agency. In the end, it was going to cost more and did not improve care. The initiative was aborted.

AOHC believes that a strong community-based service sector, including community support agencies and mental health and addiction agencies, can and must work together better. We believe that if a people-centred approach is applied with a strong quality-improvement incentive and the requirements to meet high standards, agencies themselves will make decisions to transform themselves.

Health equity must also be the foundation of any integration—this is really important. We are seeing the attempt to merge culturally competent and culturally safe organizations with mainstream organizations that may not achieve equitable health outcomes. Culturally appropriate, safe and competent services must have their place in a strong, community-based service sector.

Our recommendation is that the LHINs approach service integration from a people-centred and value basis that seeks to achieve enhanced care and improved health outcomes for people, and set high standards for quality of care and accountability, rather than simply reducing the number of service providers.

Culturally appropriate, competent and safe services must be considered in any plan to integrate and coordinate community-based services. Aboriginal, First Nations and francophone services need to be protected and enhanced.

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The act needs to be amended to identify the process to establish new health service providers as needed. There's an understanding that we have many HSPs, but there are some LHINs where there are not sufficient HSPs, and the act does not actually enable the creation of new ones. The power granted to the LHINs to order, merge, amalgamate and dissolve organizations must be used sparingly and with great caution.

The Chair (Mr. Ernie Hardeman): Five minutes.

Ms. Adrianna Tetley: Five minutes.

Community engagement: To transform the health service system requires robust, bold leadership, meaningful community engagement and strong public education. The LHINs have said that this is a core value, and the act requires the LHINs to engage with the community of persons and entities involved to do this. We are mindful that this is probably the area of the most criticism that the LHINs are going to receive, and we give a number of examples of the wide variety of community engagement that has happened across the LHINs.

In 2006, AOHC commissioned a study that basically says that you need to do community engagement because it will increase the health of communities and the effectiveness of their care. We also know that less meaningful engagement involves decision-making, simply sharing information or consulting to gather information, and more meaningful means that we need to have active participation of community members in contributing to decisions that are made. AOHC contends that the LHINs engage at this level of sharing and consulting to gather information.

We're pleased that the LHIN is actually supporting community governance, and that is not being questioned, and we're happy that the LHINs are continuing to support the need for it to continue. But we do not believe that the LHINs have successfully harnessed the power of community governance. Community governance is the highest level of the hierarchy of community engagement, yet the LHINs rarely meet with board members of HSPs in meaningful engagement.

The community is also not defined in the act. As the committee begins its cross-province hearings, we urge you to ask your delegations what "community" means. We further urge you to explore this idea over the course of the year, as we go forward.

I will go through the recommendations for meaningful community engagement:

(1) "Community" must be defined, and the act must be amended accordingly.

(2) LHINs need to build their knowledge and capacity to conduct more meaningful community engagement.

(3) LHINs need to engage with the public, community and health service providers as partners to transform the health system.

(4) LHINs need to do public education on how the health system changes will improve the health and well-being of the person, their family and the communities.

(5) LHINs should be held accountable for their community engagement process, clearly outlining the process and reporting on the number of complaints per year in their MLPAs.

(6) Like HSPs are required to do client satisfaction surveys, LHINs should be required to do independent community engagement satisfaction surveys of communities and HSPs, and they should report annually.

(7) Community-governed not-for profit health care services must be maintained.

Number eight: appropriately resourced. I think what I'm going to do is go right straight to the recommendations under appropriately resourced.

(1) The act should be amended to establish a one-way valve. This is really important. We need to prohibit the flow of funding from community health organizations into acute care institutions and should include protection of community organizations from supplementing deficits incurred in other parts of the health system.

(2) As submitted by the LHINs, the regulation should be enacted that permits the LHINs and the health service providers to receive multi-year funding and carry forward surplus.

(3) The ministry needs to significantly invest in community-based services in order to increase the capacity and infrastructure of community support agencies and not just in programs.

(4) The LHINs need to strengthen the capacity of the community health sector by prioritizing investment in human resources, operations, information management systems and quality improvement.

(5) The ministry and the LHINs need to align the capital policies to support the development of integrated and coordinated community services, allowing for business plans that include co-locations, creation of community hubs and ensuring all LHIN and ministry funding is considered eligible for capital planning.

(6) HSPs need to be able to submit funding requests for urgently needed programs and services for high-needs populations that often do not align with ministry and LHIN priorities. This is essential to achieve equitable health outcomes.

Number nine: LHIN and HSP recommendations. We'll go straight over to the recommendations. This is my last set.

(1) The MLPA should measure the health and well-being outcomes of the people they serve through a health equity lens, and these measures should reflect the full continuum of care; and it should require that the LHINs conduct community engagement satisfaction and HSP satisfaction surveys.

(2) The act should be amended to include an appeal or resolution process that requires the ministry to take action if community feedback indicates dissatisfaction with the extent and the quality of community engagement undertaken by the LHINs.

(3) The act should identify an appeal process for HSPs if the LHIN has been alleged to breach their role.

(4) While recognizing the fiduciary, oversight and planning responsibilities of the LHIN, the HSP accountability agreements need to be more collaborative and engage HSPs more as partners.

These are our initial thoughts, and we certainly look forward to questions on many of these various areas. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. I believe, with the committee's consent, this would be the time we recess until the statements in the House are made. We hope that you

will be here for the rest of the presentation, and any part of the presentation you had to go over a little lightly, hopefully that will come out in the questions and answers. Thank you very much.

With that, we're recessed until the statements in the House are finished.

The committee recessed from 1436 to 1524.

The Chair (Mr. Ernie Hardeman): I call the committee back to order. We thank you, first of all, and apologize for making you wait, but I'm sure that you—well, no, you didn't know the questions so you weren't able to formulate all the answers while we were away, but I'm sure that they will be fine. I think we'll start the questioning with the government side this time. Ms. Jaczek?

Ms. Helena Jaczek: Thank you very much, Chair, and thank you, Ms. Tetley, for your presentation with a lot of suggestions and ideas. Obviously, you have given this a lot of thought.

I think perhaps I will start off with one of your suggestions, which I was very interested in and certainly agreed with. This was in relation to population health planning. I'm looking at page 8 at this point. Your recommendation: "The act should be amended to incorporate the requirement for the LHINs and the public health unit(s) to form an equal partnership to develop LHIN-based population-needs-based plans with a health equity lens." I guess I would like to point out a practical difficulty in that boundaries of LHINs do not follow public health unit boundaries. Have you given any thought as to how this could work? As an example, my constituents live in the Central LHIN, and the Central LHIN would include parts of three health units. How do you see that becoming a reality, then?

Ms. Adrianna Tetley: I think there are two points I'd like to speak to: One is the boundaries, and one is the role and relationship. I think when I was looking at the Hansards up until now, it's impossible to put the public health units under the LHINs because of the municipal relationship. My sense upon reflecting on this is that it's not about "under the LHINs"; I think that they need to figure out how to work in partnership.

Health service providers are asked to work in partnership, so in many ways, the LHIN CEO could be working with the medical officers of health from the three LHINs to figure out how to do this. We do know that the LHINs are divided by sub-LHIN regions. Without even touching the boundary issues, the sub-LHIN regions could probably align with the public health unit boundaries and figure out how to do this. Once you've figured out the parts of each region, the epidemiologists should be able to figure out the data to develop a plan. So I think it's possible to do it.

The question around the boundary question: I do think that either the LHIN boundaries or the public health boundaries should be determined to be the same, whether you have three that are totally aligned, or whether you slightly adjust the LHIN boundaries so that they align. It makes sense to align them. But the lack of alignment

should not prohibit this from happening. These epidemiologists can break it down to postal codes. So once you've figured it out once, then you should be able to say, "Get the three epidemiologists from the three public health units to work with the LHINs," and you should be able to figure out a set that belongs to that LHIN.

Ms. Helena Jaczek: Okay, I take your point. The preferred option is clearly to ensure that they work together, and that's the essence of it. But since boundaries are something very dear to my heart, especially as we also have heard about—and you allude to this as well: that there should be much more on the upstream side. So looking at the social determinants of health is absolutely crucial, and again, whether you're looking at supportive housing or whether you're looking at the justice system—and we heard some testimony last week in relation to the Toronto Central LHIN doing a lot of work in relation to the justice system. Of course, police forces are municipally based; again, those boundaries do not coincide simply to the LHIN boundaries, so it does complicate the situation. In theory, as you say, down to postal codes, though, it becomes very, very problematic.

I guess what has become apparent is that within the 14 LHINs, some LHINs have subdivided into areas where there might potentially be some sort of community of interest. But certainly, given the geography in the Central LHIN and the very diverse populations that exist within the Central LHIN, there certainly is no one community of interest; there are multiple. And I'm sure with your experience with CHCs—when you're dealing with your specific population within a CHC, you presumably are able to work very well in terms of looking at determinants of health and making sure that the partners work together.

Can you give us some examples, perhaps, of where CHCs are working effectively with LHINs and perhaps point to what makes those successes, and if you have some examples where things may not be working so well? What sort of criteria make it work? Can you just sort of give us some concrete examples like that?

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Ms. Adrianna Tetley: Sure. I think I'll look at the South East LHIN. The South East LHIN is the LHIN that actually also works well with public health. They know their CHCs well. They understand the breadth of them. One valuable thing about the South East LHIN is that there are five CHCs sporadically spread across the entire LHIN, so there's sort of a CHC in each community that needs to be done. The LHINs understand their role. The CHCs work well together. They work well with public health. Together they're able to figure out what it is that needs to be done and how they can move forward.

The LHINs in that particular area understand and recognize their role. The Kingston community health centre has, as its partners, immigrant services, early years programs and Pathways to Education, so it has the full breadth of the determinants of health within the community health centre, and that LHIN recognizes it and supports that work. I think that they have a very much

community approach and they invest in the CHCs to continue to explore and meet the needs of a people-centred system. They are an example of where it's worked really well together.

Ms. Helena Jaczek: Do you have some examples where things are not working as well?

Ms. Adrianna Tetley: In another LHIN, which won't be named—LHINs have been around for seven years, and they went to an AGM of a community health centre and were surprised at the breadth of services that a CHC provides. In some LHINs, the CHCs are viewed as primary care in the very narrow sense of the word. LHINs are not interested in the breadth of the work that they do. The LHINs are interested in how many people they're seeing—doctors and nurse practitioners. They're not interested in oral health, because that's public health units. They're not interested in what they might be doing in the breadth of their services. So in essence, they may be interested in about a third of what the CHC actually does. In that case, the CHC does not feel like they're part of the LHIN's agenda. They're not being invested in as part of the solution, and the relationship is a relationship of accountability, to do what you have to do to report back to keep your funding. But it's not a partnership and it's not collaborative.

Ms. Helena Jaczek: So there's some variability, then.

Ms. Adrianna Tetley: There's huge variability across the 14 LHINs.

Ms. Helena Jaczek: Do you, as the ED of the association of community health centres, get together with the LHIN leads, the CEOs? Is there some sort of coming-together on a provincial basis to discuss these issues?

Ms. Adrianna Tetley: No. We have actually—there are a couple of answers to that. The LHIN has now set up a LHIN strategic council. In that, it has representatives of LHIN CEOs and it has all of the provincial associations who are there, and we're starting to meet quarterly—this has happened in the last couple of years—where we can raise these kinds of issues.

When we're raising sector-specific issues, it varies. The tables are not always available, and there's a sense that they need to speak to their HSPs directly and not necessarily hear the association voices. So we've constantly, from the beginning, felt that there is a provincial role to ensure provincial standards, to ensure a provincial voice, and to sort of ensure that there is equitable support for the CHCs, regardless of which LHINs they're in. The LHIN strategic council is a place where it's starting to happen, but at that table, it's about strategic issues and you're not to bring sector-specific issues to that table. To bring sector-specific issues to the table has very limited opportunities.

Ms. Helena Jaczek: Each LHIN has a primary care lead, as I understand it. Of course, in your presentation, you've argued throughout, really, that there should be far more emphasis on the primary care piece, on the prevention piece. How do you feel the primary care leads are working within—

Ms. Adrianna Tetley: Again, it varies across the 14 LHINs. I would say that the primary care leads, generally and not individually, are mostly not focused on CHCs. Oftentimes, the CHCs are forgotten as part of primary care in different policy discussions, and we often have to remind that CHCs are also primary care. But mostly the leads are focused on how to organize the unorganized primary care system. They're more focused on the fee-for-service docs, the family health groups and the groups that are what we call unorganized. Only 25% of primary care is in an organized model—an organized model being community health centres, aboriginal health access centres, nurse-practitioner-led clinics and the family health teams. The rest are out there on their own and not even in any network. Oftentimes, the primary care providers are focused on that 75%: How do we get those primary care providers engaged in moving forward and transforming the system?

Ms. Helena Jaczek: That's surprising to me. I would have thought that the easier way of engaging primary care would be with the established CHCs, especially when there are successes like the Kingston one that you told us about. So that is very interesting.

If primary care becomes more the responsibility of the LHIN, you suggest developing a transition strategy. Could you give us some of your ideas on what that might look like?

Ms. Adrianna Tetley: Yes. We have quite a few thoughts about how to do this. I'll just use concrete examples. We have a community health centre in a community where there is a solo fee-for-service doctor working in an adjoining community. He actually wants to work with the community health centre in the community because he's by himself as a fee-for-service doctor. I think he has a nurse who works with him. He's got complex clients for whom he wants access to the inter-professional team model that's at the CHC. So we have submitted a proposal to move the fee-for-service physician to the CHC model. The issue becomes the OHIP pool and where the dollars are sitting. The OHIP pool for that physician pays for not just the physician, it also pays for rent and it pays for the nurse that they have there. What the ministry is currently doing is looking at what it would cost to put that person on salary. But the salary is only a piece of it. If you're going to take people over, they will be accessing the interprofessional team. The issue is, how do you transition that fee-for-service doctor, who wants to go, into the local community health centre?

Another example that we have is the one that I alluded to in the report, where I had to go quickly, where there actually are seven primary care physicians who have been working by themselves in rural Ontario for years, so they have very large rosters. They're all over 65, some over 75. In that particular region, there are no family health teams; there's just a CHC. They would like to engage, the physicians would like a transition strategy to start moving over now. They would love to go into semi-retirement, start moving their positions over so that if

something happens to them, or they can plan retirement—they can start to transition the people. The question becomes, and in the historical decision, if there are seven physicians in that community, who do you replace them with? Do you need a mix of interprofessional teams that includes nurse practitioners, dietitians and social workers? Maybe you don't need as many physicians, and we know the physicians are the most expensive part of the system. If you can use that money that equates it and transfer it over, my sense is you can really develop a strong interprofessional team that can meet the needs of the people with probably less money than finding seven individual physicians to run seven individual practices in their own sites with their own space. But one is in an OHIP pool, one is the funding, and one is in the LHIN-funded role. So how you transition between those pools is very important.

There's another rural example, in another part of Ontario, where the physician gave lots of notice and said, "I'm leaving town. Let's transition to the CHC." He was leaving. Nothing happened. Everybody was saying, "Who's on first?" "Who's on second?" Nothing happened. The person has now left, and there are 3,000 orphan patients.

Ms. Helena Jaczek: So was there any role for the LHINs at this point in time in sort of facilitating these discussions with the ministry?

Ms. Adrianna Tetley: I think they're starting to have these conversations. It's a result of us; we've brought these three cases to the ministry and to the LHINs, and we're starting to engage with both the LHINs and the ministry.

Everybody is sort of saying that the minister's action plan says that the LHINs shall plan primary care, but no one has done any thinking beyond that. What would that look like? How would it be done? They're initially starting to think about it. The LHINs are sort of going, "Oh. Okay. How do I do this? How do I even begin to think about a mix of models?"

A mix of models is also very important. We did a study in Ontario that says about 22% of the population needs the kinds of services that are provided by community health centres. They need more complex, coordinated, comprehensive care that also deals with determinants of health. Some communities might need them, others not, but generally 22%.

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The LHIN needs to plan. That's why the population-needs plan is so important. They need to do what South East LHIN did, and do a deprivation index and say, "Okay, this community needs a community health centre; in that community a family health team will work." So the whole issue of population planning, plus having to be responsible to plan for primary care, is essential in coming together. I just think that at the moment, it has not been the mandate of the LHINs and they're trying to figure out how to do it, but they haven't been given a mandate to require them to do it.

Ms. Helena Jaczek: In other words, that might be an area where the act should be amended to really push that kind of planning.

Ms. Adrianna Tetley: Planning from a person's perspective, not the provider perspective. That's fundamentally a key change in primary care.

Ms. Helena Jaczek: Yes, and looking at all the appropriate models that might exist. As you know very well, I represent an area of York region and we do not have a single community health centre in York region.

The Chair (Mr. Ernie Hardeman): Say it ain't so.

Interjection.

Ms. Helena Jaczek: You have one in Vaughan?

Mr. Steven Del Duca: I do.

Ms. Helena Jaczek: Oh, my goodness.

Ms. Adrianna Tetley: In Vaughan, yes. Vaughan has got a new one.

Ms. Helena Jaczek: Okay. A new one? That's excellent.

Ms. Adrianna Tetley: Vaughan got it in 2007, so it's running.

Ms. Helena Jaczek: In terms of future planning—

The Chair (Mr. Ernie Hardeman): Four minutes.

Mr. Mike Colle: Vaughan's got everything.

Ms. Helena Jaczek: One last word, because as you know, I'm a great proponent of a potential new CHC in Markham and Richmond Hill. How are you finding your conversations with the LHIN? Is there any movement going on—

Ms. Adrianna Tetley: No.

Ms. Helena Jaczek: —now that I know that Vaughan has one?

Ms. Adrianna Tetley: Vaughan has one, so the particular agency that is there is trying to become a health service provider, as a starting point. No one knows how to create new health service providers. There doesn't seem to be enabling legislation to create new health service providers, so that's step one.

Step two is that there's a sense that they're not taking a population-needs-based approach. They're saying, "Well, we have family health teams. We don't need CHCs"—the lack, again, of understanding what the community health centre is and what its unique role is. We know that the population in that particular area has gotten huge with new immigrants, and it's growing every year, so the current family health teams (a) aren't designed to meet their needs, and (b) we need new CHCs in that community to meet these needs. We will see a big difference in terms of their health outcomes if we have community health centres. There is an agency there willing and ready to go. There's no place to have this conversation currently.

Ms. Helena Jaczek: So that's this piece where you're saying that the legislation needs to be amended to include the opportunity for new health service providers?

Ms. Adrianna Tetley: Absolutely.

Ms. Helena Jaczek: Okay. That really helps.

You have a recommendation on page 15 about a "one-way valve" prohibiting the flow of funding from

community health organizations into acute care institutions.” When you’re saying community health organizations, you would obviously include the CCACs?

Ms. Adrianna Tetley: Yes.

Ms. Helena Jaczek: Yes, you would, because I think that is absolutely crucial. I would definitely agree with you. Are you aware of situations where, in fact, funding has been shifted?

Ms. Adrianna Tetley: Oh, absolutely. Surplus dollars from community health centres have, over the years, been used to pay deficits of hospitals. Absolutely.

Ms. Helena Jaczek: Okay. I’ll reserve whatever we’ve got, a minute or so.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. I think you have a minute to spare. The official opposition: Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Chair, and good afternoon, Ms. Tetley. It’s great to see you again, and thank you very much for your very comprehensive report and number of recommendations.

I’d like to just get some further thoughts, if I might, from you on the issue of equitable health outcomes. On page 5, you’re talking about how the objective in the act would be expanded to ensure equitable health outcomes in a variety of communities. I wonder if you could tell us a bit more about what some of the barriers are and some of the solutions that you would propose.

Ms. Adrianna Tetley: I think that I’m going to use Fred as an example. Do people know who Fred is? Fred is the poster person for health links. He’s described as 50-some years old, living alone. He has 26 different illnesses and he costs the system a lot of money because he’s going from specialist to specialist, and no one cares for him.

There are two different kinds of Fred. You can have a Fred who lives at home alone, as I said, but he has a sufficient amount of money to buy extra care. His two daughters have a university education, and they’re helping him navigate the system.

Then there’s Fred number 2, who doesn’t speak any English, has no family in town, is living on old age pension and has no ability to buy any extra services, and doesn’t eat properly, because he doesn’t have enough food.

The health system looks at them generically, as if they’re one person. The kind of need that Fred 1 has and the kind of need Fred 2 has are very different. Unless we’re very, very deliberate in trying to figure out the needs for Fred 2, he’s not going to having as equitable health outcomes as Fred 1.

Seniors are another question. We look at the health outcomes for seniors, but what about aboriginal seniors versus francophone seniors versus seniors living in poverty? Generically, we might say, “Okay. We’ve reached 60%.” But maybe it’s because we’ve reached 40% for aboriginal seniors and 80% for seniors who live in Forest Hill.

The health equity impact assessment tool actually outlines all the various things that you need to take into

consideration to actually measure and break down populations into different kinds of population in order to measure their equitable health outcomes. Seniors with mental health issues versus seniors who don’t have mental health issues: unless we start looking at that, we’re not going to design—another really good example I just heard is with health links. They were going to look at 37 people who were identified as higher users of the health system. They did phone surveys. Of the 37 people, 17 they reached on the phone, and those 17 had a physician. The 20, they said, “Well, we’ve discovered they don’t have phones, and they actually are unattached to a physician, so we’re just going to go with the results of the 17.” Just imagine the different story they’d have if they actually reached out and got the 20 who don’t have phones, who don’t have a physician. A very different care plan would need to be designed for those 20 they didn’t reach instead of planning the whole system on the 17 they did reach.

I’m not sure if I’m answering your question, but that’s why we need to have a very deliberate health equity lens, or we are not going to get the same outcomes for people, whether they live in the north, whether they’re franco-phone, aboriginal, live in poverty, new immigrants in Helena’s riding, where they’re looking for a new community health centre. It’s pivotal to making sure we have equitable health outcomes.

Mrs. Christine Elliott: Thank you very much. I also had a question on page 10. Please forgive me; I forgot my glasses today, so I’m having a little trouble. It has to do with the system navigation, and I’m wondering just what that would look like in your view.

Ms. Adrianna Tetley: We really differentiate between care coordination and system navigation—just to make sure we have the words. For us, system navigation is when a person who needs care would be needing to navigate the system, and navigating the system might be as much about going to the food bank, getting to an employment office, helping them write a resumé—navigating the system to get the kind of care that they need. It’s much broader and has a much greater breadth in the scope of what they do. It might be helping them get their OHIP card. It might be helping them get into school.

Care coordination for us is when a person is sick and needs intensive care. They need intensive care coordination going into the system. But, for us, that care coordination could start as a young mom who has a baby, and helping them figure out how to provide good care to that baby. The baby may be sick, or may not, but they may need to understand how to keep breastfeeding. They might need to make sure that the baby is hitting all of those different milestones. Maybe they’ve got a speech impediment, and so they may need to get help for that speech impediment.

That child grows up, and they become early years—they have issues that arise. They become a teenager, and that teenager child might need to access mental health services. They might need sexual reproduction classes.

They might need those kinds of services. Later in life, that person might develop cancer and need very intensive cancer support, and then later in life, again, palliative care.

So for us, why it's so important is that if you live in the same community, your primary care provider is the person who will stay with you from when you have that baby to when that baby needs palliative care. In our world, you're connected to the same primary health care system that planned that place, that will ensure that you go into the system and back out of the system as required, when needed, and you will ensure that your care is done in and out.

In community health centres, they've been doing system navigation and care coordination from its model. In some cases, depending on what it is, the system navigator may be a peer support worker, and that might be the best way to work with them. In other cases, when they get into care coordination that gets complicated, they may have an RN.

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The bottom line is, it's the community health centre that is responsible to ensure that they come in and they come back because, hopefully, when they're intersecting with the rest of the system—even with cancer, it's episodic, it's for a period of their life, but eventually we want them back at the community health centre, which knows their story as they go from birth to death. The Kingston model that we talked about talks from cradle to grave. So for us, it needs to be firmly—the resources need to be located in there, and then accessing the resources as they're required.

Mrs. Christine Elliott: I guess I would take from what you're saying that there isn't a specific health care professional that would be doing the system navigation. It would just depend on what the issue is at hand that would dictate who the appropriate person would be.

Ms. Adrianna Tetley: Absolutely.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. McKenna.

Mrs. Jane McKenna: Hi. Thank you so much again for coming. My first question is that you had said to Ms. Jaczek that you made a key change so now it's a person provider. When did that change—

Ms. Adrianna Tetley: Sorry? When it went from person—

Mrs. Jane McKenna: Now that it's patient-centred and that you've made that key change—when was that?

Ms. Adrianna Tetley: Right. CHCs have always used the word "client" in the past; we've never used "patient." Patient, in our mind, meant that you were sick and that's partly—when you take the model of somebody is sick, you enter the hospital, you're their patient. Oftentimes, if you have a teenager who needs sexual education as part of staying healthy, they're not sick; they need education about good sexual health behaviour. We have used the word "client." There is a lot of pushback on the word "client" and now we're using "person-centred care." It's

a definition that's used by the WHO; it defines "people" and "person-centred care."

What's also really important in the word "person" is the responsibility to take care of your own health and to work in partnership with your provider as opposed to the provider being the expert telling you what to do. It's a dynamic on many fronts, and starts with you as the person.

Mrs. Jane McKenna: And how has your relationship evolved over the last seven years with the LHINs?

Ms. Adrianna Tetley: I think over time, it's maturing. In some areas, as I think I said earlier, the relationship has been very productive and is working well together. In other areas—why we're recommending the expansion to the LHIN act, as we're talking about it, is because there are many parts of the health system that we feel are not—the LHIN is responsible to plan and oversee the whole health system, and yet the LHIN act itself is focused on a small part of the health system. So where the frustration comes with the LHINs is when they do not see the entire spectrum of what we believe is health and well-being and the responsibility of the LHIN.

We also fundamentally believe that we need to keep people healthy in order to sustain our health care system in the long run. The longer we, in our rooms, stay healthy and don't need the system, the more it will be there when we need it. But we want to make sure that people who don't need it stay healthy in order to prevent them from having to use the system. So we need a robust, healthy, acute system. We need long-term-care facilities. We need each part of the system. But we're saying now, if we're going to have a sustainable system, we need to focus on developing mental health services, community support services and primary care. They need to be equally supported and robust in order to have a full continuum of care that will impact the sustainability of our system in the long run.

Mrs. Jane McKenna: So why do you think that they stay so close in their silos? I'm sorry, I can't see what page that was on either, but you do mention that everyone very much stays in their silos in that area.

Ms. Adrianna Tetley: The silos I spoke to were related to primary care and the silos I spoke to were related to public health. I think if you look at the LHINs' mandate again, if you go back and look at the objects, it's very much about managing the current health service providers. Even though it says "equity," it's about managing the current system. All of the indicators, all of the work, the 14 of the 15, are acute-focused. You're going to measure what matters, and if you say only emergency room and use of hospitals is what we're going to measure, then for us that's sending a signal that that's what matters. If you're going to start really being part of the system and feeling part of the system, you've got to measure what community support and primary care actually do, because that's what tells the story and that's what begins to challenge health service providers as well to improve and to do better.

But, you know, the whole thing is, you measure what matters, and if we're just measuring acute, then the system and the focus will only be on the acute.

Mrs. Jane McKenna: That's it for me, thank you.

The Chair (Mr. Ernie Hardeman): Ms. Forster?

Ms. Cindy Forster: Sure. Good afternoon. Just a couple of question, and then I'm going to give the rest of the time to France. You talked about the fact that primary health care organizations should provide the system navigation. Currently the CCAC does some of that navigation. So are you suggesting that there wouldn't be any role for the CCAC, that primary health organizations should take over the whole system or forge a closer relationship where they're actually working together to navigate the system?

Ms. Adrianna Tetley: So let's start by saying that CCACs do a narrow part of what I believe care coordination is, because care coordination can happen from birth until death. Their focus, predominantly, is on seniors and complex children. First of all, when I talk about care coordination, I'm talking about care coordination through a life, right? So that's first.

The second piece is that whatever the role of the CCACs is in the future, we are not there yet. We need to build a robust primary health care system in order to do care coordination. I believe currently the CCACs have the capacity to do that now. Many of our CCACs do it and do not work in partnership with the CHCs to do their care coordination because it would be seen as a duplication; it's something they already do. However, there are certain times when even the CHCs have to interact with how the CCACs are currently structured, because if you're going to do care at home or palliative care, you're going to need to do it for that time where you may need to have to connect with CCACs to do that service.

So I don't want to get into the argument or the discussion about what's the future role of CCACs. What I'm saying is a high-performing primary health system should do care coordination for the people that they serve. There may be times where they need to connect depending on how the system evolves—to connect with the CCACs for that period of their life when they need services that CCAC is the doorway to accessing those services. They may need to actually partner with CCACs to get that service.

Ms. Cindy Forster: And then you talked more about the fact that we're not really spending enough energy on health promotion and health prevention. Public health is dedicated to doing some of that work, but they only get a very small percentage of the health care budget to do that work. So do you see public health getting more dollars to move their mandates along, or do you see these as dual roles?

Ms. Adrianna Tetley: There's a very interesting debate happening in public health between public health and population planning and direct service. I know in Nova Scotia, public health has decided that they will no longer do direct service. They will no longer provide flu

shots, for example—flu shots or breastfeeding clinics, that should be done by primary care.

We need a healthy debate about the role of public health in direct service. Having said that, we do need public health to have a robust conversation about population health. That's their mandate. We need clean water, clean air and many things. They need to be working in partnership with LHINs to determine how that can be done together. I think the question is, who does direct service and what kind of programs and services should those be? Absolutely, on health prevention and promotion, when it's around clear water and clean air, that is the role, and the public health units need to be invested to ensure that we have a healthy space and environment to live in. The question that I think is important is the direct service piece and who should do it.

Ms. Cindy Forster: Okay. My last question is, you also talked about the CHCs and primary care assisting people with housing issues, social service, education and all those things that directly impact people's health, but you didn't speak to the transportation piece, which I think is huge, particularly for rural, northern communities or even where I come from in Niagara, where there isn't a reliable inter-regional bus system. What are your comments around that?

Ms. Adrianna Tetley: Transportation is a key determinant of health—getting to a specialist and anywhere for appointments. CHCs play a role in mitigating transportation issues. How they do that is, if it's an urban area, they often provide TTC tickets or taxi chits to get to the specialist appointments. In rural areas, they do mobile health clinics. They go to where the people are. They organize transportation. One CHC, I think, told me that they did over 10,000 transportation trips, mostly with volunteers that they organized. So transportation is a key determinant, both in rural and urban areas.

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Ms. Cindy Forster: So you'd agree that we need to turn our minds to that piece as well if we're going to be moving into this new era.

Ms. Adrianna Tetley: What's really important—I think I said this; I'm not sure. The LHINs have worked, as far as I can tell, anyway, in silos from their counterparts in their region. Have the LHINs sat down with the boards of education and said, "What are the health issues facing your kids and how can we work together to help to do that?" Have they sat down with the municipality and said, "What are some common issues that we need to do around transportation? Maybe we need to provide better TransCare. How do we work together to actually be developing these system solutions?" It's just like a CHC. The CHCs partner with people. They don't necessarily do it themselves, but they ensure that their clients have access to the services that they need.

It's the same thing with the LHINs. Maybe in partnership with school boards, with the municipalities, with other large organizations, they could figure out what is the plan to keep our communities healthy. The LHINs don't see their role in the community. They see their role,

at the moment, as treating people when they're sick and the patients who are in the system. That's one of the frustrations with the community health centres, because their role is community resilience and that's not valued or seen as important currently within the act, and if it's not in the act, it's not going to be in their mandate.

Ms. Cindy Forster: Thank you.

The Chair (Mr. Ernie Hardeman): Yes, Ms. Gélinas.

M^{me} France Gélinas: Thank you for coming again. My first question has to do with—you talk about the aboriginal and First Nation Health Council and planning entities, as well as the francophone population, and the fact that the way the system is set up right now where francophones, where the entities exist, have to sign an accountability agreement, which makes it awkward. Would you have any recommendations as to what should change?

Ms. Adrianna Tetley: Yes. I think, first of all, the councils—one has met; one hasn't met frequently. The importance of having an aboriginal and a francophone health strategy in this province is paramount, and it hasn't happened to date in a serious way.

Around the planning entities themselves, I actually believe that the planning entities should be treated—just like I believe in public health units being equal partners with the LHINs, the planning entities need to be equal partners with the LHINs. Because there's money flowed to them, some kind of accountability over the money needs to be developed, but fundamentally I do not believe that they should have an accountability agreement with their LHIN under the direction of the LHIN. If they're going to provide advice to the LHIN in planning, there needs to be a parallel partnership.

We talk a lot about the ministry's role and stewardship and the LHINs' role in planning and accountability, but I think the planning entities have to have a distinct and separate role. They can't be treated as health service providers. They are not providing direct service. They are planners, and they need to have a step removed from an HSP relationship.

M^{me} France Gélinas: You made the parallel to the equal role with public health units. Would the same train of thought apply where the health units continue to be funded directly by the province but work more collaboratively?

Ms. Adrianna Tetley: Yes. I think that's the direction that we need to go. I do know, from the previous questions, that there's always a thorny issue with the relationships with the public health units with the LHINs, and I think it's the wrong question. We need to say that form follows function. What's the role of the public health unit and how can they work with the LHINs to achieve that role? There's always this issue that the only way that something can happen is if they're under the LHIN.

I put the planning entities in the same boat. They're planners. They're population planning bodies. Public health is a population planning body. We need to look at—maybe it's a council with the LHIN, the planning entities and the public health units working collaboratively to figure out how to plan for the best health and well-

being of the individuals, the families and communities. So I think it needs to be a relationship that is at a higher level, as opposed to a relationship that is hierarchal.

M^{me} France Gélinas: You also talked a lot about primary care planning. Basically, the act mentions it in the opening statement, and then it's not there anymore. What would you recommend we do to change this, and what is the outcome you hope to get?

Ms. Adrianna Tetley: I think the act does not actually name primary care. It names health equity, but I don't think the words "primary care" are in there, actually—

M^{me} France Gélinas: You're right.

Ms. Adrianna Tetley: —so I think the objects need to be changed to mandate primary care. We believe that we need a system of primary care where every Ontarian has access to interprofessional primary health care working to full scope that provides a continuum of care that's integrated and coordinated.

To do that, we believe the LHINs have to have a role, a responsibility and the ability to actually develop those plans and implement them. We need it to be named, because if it's not named in the act, they will focus on what's named in the act. We know this because, for two years ago now, the minister in her action plan said that LHINs should plan primary care, and yet the conversation is only starting.

Often it was interesting for me when I read the Hansards that the comments were focused on "Well, we've got health links now," as if that equates to primary care planning. For me, health links does not equate to primary care planning. I support health links, and I think they're an important way of bringing people together, but that's not planning for when the doctors are going to retire, what's going to happen and what kind of system we need.

All the research shows that if people have care and they feel connected to a primary health care place, they will save the system money, and they will be healthier. We really do need to focus on that.

M^{me} France Gélinas: On a dollars-and-cents track, do you see the LHINs being responsible for funding primary care?

Ms. Adrianna Tetley: Determining what the salary is for a physician or the OMA agreement is one thing, and I think that belongs in the ministry. There's no way you're going to get a provincial agreement on that, but when we talk about primary health care, they're way more than physicians. It's about nurse practitioners, social workers, dietitians, health promoters and community workers.

Yes, of course they need to fund that, and they need to figure out how to work together. They do need to have an ability to transfer money from physician fees. If the LHINs decide that they need interprofessional teams, maybe the money needs to transfer over. But what you actually pay and how you're going to negotiate, which is typically the OMA agreement—you'll bog the LHINs down. I don't see that transferring. But that doesn't mean it can continue as it is.

Historically, the OMA have dictated the policy about how primary care develops over the years. I was at a meeting earlier today, and they know what I was going to say here today. There are new people who help to shape primary health care; it's more than the OMA now, and they need to share the stage.

How you're going to pay them and what they get paid, I don't think the LHINs should get into that. But needing to transfer some of the money—if it's an example where seven doctors are leaving and need to be replaced by a team, there needs to be the ability to make sure that the people get the right care they need. That may mean moving money from one pot to another and enabling that to happen, or you leave the pot and create a new pot of money to provide interprofessional teams. The mechanism for funding is not as important as that it get funded, that it's people-centred and that the people get the care they need.

M^{me} France Gélinas: How much time do I have left, Chair?

The Chair (Mr. Ernie Hardeman): About six and a half or seven minutes.

M^{me} France Gélinas: Okay. At the end of your presentation, you started to be quite rushed. I was wondering if there were elements of those recommendations that you wanted to make sure that we include when we look at how we change the system.

Ms. Adrianna Tetley: I do want to speak about two points. I'll talk about community engagement and accountability together. First of all, I know that the system needs a serious health system transformation. It is very hard for the LHINs, or anybody else, to do their job. Before the LHINs, it was health system restructuring; it was the ministry.

We need to have meaningful community engagement, where people feel that they're part of the system, so that when tough decisions have to be made, like a hospital service being moved into the community, the community is part of that decision so that they're with the tough decision as opposed to opposing it. I fundamentally believe that the LHINs have not yet figured out how to do meaningful community engagement. It's been very much, "Come meet with me. Tell me your ideas," and then they go away. The HSP—a lot of the board-to-board meetings are very much one-way. They're not real engagement.

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The other point is the definition of "community." We talked a little bit about community being the soul. It can be geographic; it can be cultural. There can be many different ways of defining community, and I think the act doesn't define "community." You can say a community board is the size of a LHIN. I don't believe a community board is the size of a LHIN. That's not a community. It might have a not-for-profit board, but that doesn't mean it's community.

I think you do need to grapple with what community means, and how do we do this and how do we engage community in a meaningful way in order to do the tough

changes that we believe need to happen to make the system more informed.

Having said that, I think there's also a mandate—

M^{me} France Gélinas: Sorry, Adrianna. Do you see this definition being put in the act?

Ms. Adrianna Tetley: I think we need to grapple with it as part of this review and to determine what might be the best. I don't know whether it should actually be in it. I absolutely think it is a question that should be explored, to figure out what we mean by community, and then what that means.

The second is the accountability of the LHINs. There's lots of one-way accountability between the HSPs and the LHINs, but there's not a lot of accountability for the LHINs. As we've alluded to, not everybody's perfect. Sometimes some LHINs are better than others, and there are some great LHINs. But sometimes there's a bad apple in the box. There's nothing to do by an HSP or the community. There's no appeal process in the act. There's no ability to hold that LHIN accountable in any way.

I had really strong ideas about—as you're an employer, you're required to do employee satisfaction surveys. You're required to do client satisfaction surveys. Why not require the LHINs to report on their complaint process, report on their community engagement process, do third party independent HSP reviews, in order to measure how well they're doing community engagement, in order to measure how well they're doing with their providers? I think that's a very, very important part of moving forward on accountability.

My final point is about appropriately resourcing. Right now—and people better than me know the percentage of the fund that the community-based services have—it's a very, very small part of the budget. We're being kept at 0%, the same way as the hospitals, yet we're being asked to take on more and more and more.

If we fundamentally believe in a health system that is illness prevention and health promotion, we need to invest in the community sector; that means, at an operational level, infrastructure, HR or human resources, in order to make sure that it can do the role that we're asking it to do. We're asking it to stand up and do more and more. Yet when it's time to take on something—when it's time to do health links, for example—they're going, "Well, the community sector doesn't have the ability because they don't have a project manager. We'll turn to the hospital, which has a project manager. We'll use the hospital's project manager office to develop health links."

It's not because the community sector can't do that role; it's because they don't have the infrastructure to do that role. As long as we turn to the hospitals for all of those kinds of services, you'll not fundamentally create the capacity in the community sector.

We need a serious look, and that's why the one-way valve is so really important, to start building the capacity in a serious way. And a dollar goes a lot further in the community-based sector than it does in the acute sector.

M^{me} France Gélinas: What's the difference between what you're talking about, building capacity—we often hear the LHINs saying, “Oh, the community agencies should share their back office. All of the community agencies should have one HR, one finance, one etc., etc.” Are you saying the same thing?

Ms. Adrianna Tetley: No, not necessarily, but what I'm saying is, as part of my remarks, we need strong community-based services. That may mean fewer in some communities; it may be more in other communities. It may mean bringing the community support agencies together, with very high standards, so that they're strong and robust. In that case, it may not be just sharing back office.

If you just look at back office in isolation of everything else, it actually—some of our CHCs have been required to do back office. It's costing them more to do back office by sending it out than it was for them to do it in the first place. The argument was that it will provide better high-quality care—high-quality services is the argument—because the costing isn't the reason to do back office. All the research has shown that back office alone, in and of itself, does not save money.

I do think, though, that we need to build the infrastructure around—and I'm not talking about HR directors; I'm saying that if you want to move from the hospital to the community, you need to have pension plans so that the people who are working in the hospital will want to work in the community and take their pensions with them. You need to have compensation that is relatively—not equal; we never say equal to the acute sector, but at least attractive enough and equitable enough that people will want to work in the community and put their careers in the community. We need to build the capacity for larger organizations, even community health centres, community support agencies and mental health agencies that are larger, to do some of this system planning and this work.

We know, and OCSA will be the first to say it, that a lot of the smaller agencies need to figure out their future. By setting high standards around quality and by having high standards in terms of what they need to do, many of the smaller agencies will come together, but it will be done because they'll take a person-centred approach and it will be the best way to go, going forward. Over time, they will come together, doing more.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. Did the government wish to use their last minute and a half? Yes?

Ms. Helena Jaczek: Mr. Colle.

Mr. Mike Colle: One minute?

The Chair (Mr. Ernie Hardeman): Yes.

Mr. Mike Colle: It's okay. It's just a minute?

The Chair (Mr. Ernie Hardeman): Yes, a minute and a half.

Mr. Mike Colle: I've got too many questions. I can't.

The Chair (Mr. Ernie Hardeman): Nobody wants to use it?

Ms. Helena Jaczek: No.

The Chair (Mr. Ernie Hardeman): Okay. And the opposition? If not, that concludes the presentation and the questions. Thank you very much for coming in and putting up with the delay in the middle of the presentation. We commend you for coming back, full force and invigorated.

Ms. Adrianna Tetley: Thank you.

ADDICTIONS AND MENTAL HEALTH ONTARIO

The Chair (Mr. Ernie Hardeman): Next is Addictions and Mental Health Ontario: David Kelly, chief executive officer. If you will have a seat, Mr. Kelly. We thank you very much for coming in. Again, on behalf of the committee, we apologize for the hold-up. Obviously, because the first one was delayed, the second one is just as much delayed.

As with the previous one, we will ask you to make your presentation, up to a half an hour, and then we will divide another hour, with 20 minutes for each caucus. This time, the questioning will start with the official opposition.

With that, the floor is yours.

Mr. David Kelly: First, I just want to let you know who Addictions and Mental Health Ontario is. I'm going to be brief because we're actually kind of the result of some of the transformation, integration, look and understanding of health. We've come together to form a new association from two founding organizations, the Ontario Federation of Community Mental Health and Addiction Programs and Addictions Ontario. We came together to make sure that Ontarians have access to the services and supports they need to address substance misuse and mental health issues. We want to foster dignity and accountability to all clients within the system, and we're here to give hope to and transform lives for those living with mental health and addiction issues.

In a sense, we are part of the result of what's been happening in the health care system for the last few years. I'm very pleased to say that we've come together and worked with over 280 mental health and addiction programs across the province. That's the full continuum of care, from hospital-based acute programs right down to drop-in centres, front-line housing etc.

The other thing I really want to do to start off this presentation is to extend thanks to each and every one of you. We know that your leadership and support have made a difference in local health providers, particularly in mental health and addictions. We want to thank all the MPPs and all of the political parties who are addressing these complex issues through the select committee, the 10-year strategy for mental health and addictions, and for their support of funding for these services. So thank you. You may not hear that enough, but I really wanted to make sure that that got on the record.

Also, when you start looking at mental health and addictions, to understand where we are today, you actually have to look at the past. We are in a system that is dra-

matically transforming through better understanding of what's going on, but in the 1990s, we actually had reductions in the base budgets of mental health and addictions services in the province of Ontario. Zero per cent base budget increases between the years of 1992 and 2003 resulted in a drop of capacity of these services to provide and meet the needs of their communities by about 25%. That's through inflationary pressures.

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We also, in the 1990s, had policy decisions on who would be—and how to access services. That often meant that individuals needed specific diagnoses to be able to get access to community-based services. All that did, with the best of intents, was actually to create longer lines.

So you have a perfect storm brewing, where you've actually had base budgeting reductions. You've had 0% increases, so your capacity continues to diminish. You've had policy decisions about who can access the services, which meant fewer people could access those services, and they would end up showing up to family physicians and emergency rooms—all kinds of different places, except for the place where they could actually get the help that they needed.

Into that system, we were instigated. We had regional offices come through that couldn't address the issues of mental health and addictions, and we went into the LHIN process going forward. So we're in a place where we actually work at a system that was teetering. I don't want to say "turmoil," because I can only support—you cannot imagine the dedication of individuals, staff and organizations, and their boards, to keep their organizations functioning through that time period. It wasn't that the system was teetering; it was just that the system had not been worked with to actually meet the evolving needs of mental health and addiction issues.

We're here today to talk about the Local Health System Integration Act: what's working, what's not working and if we were supporting the Drummond report. In my presentation, you're going to see two slides; I'm just going to quickly hold them up so you understand which two I'm talking about.

I think I heard an earlier presenter touching on these, but the objects of this Local Health System Integration Act actually speak exactly to the heart of mental health and addictions services in many different ways: the need to collaborate, the need to integrate your approach, the need to work on these system issues to better build the health care system.

When we get to our performance agreement and our indicators, none of this is actually relevant to community-based services in the short run, but also in the sense that these are not indicators of a high-performing health care system, but are indicators of an acute system. Until we actually get out of the box of thinking of health within these acute boundaries, or family physician boundaries, and start looking at the broad determinants of health, we will continue to have to go through a continuous change in the health care system. We will not address the core

issues of maintaining and lowering our costs or making sure that people have the right access.

In mental health and addictions, if you're not talking about the broad determinants of health, if you only focus on treatment, you're only doing part of the job. People need safe places to live. They need help to find work again. They need a friend. They need social environments. They need a lot of things that are all supported in some ways, but many are outside of the health care system. We have to get to a better integration and understanding. I'm sorry; you can have as many physicians available as you want, but if you do not have safe and affordable housing, that physician is not going to be able to help you. It's very important when we talk about mental health and addictions that we understand and look at the broad determinants and not the narrow confines of legislation and the health care system.

One of the best things that I've seen happen in the last 10 years for mental health and addictions was actual increases in the ODSP rates. That meant that individuals had that much more, a little bit of money to be able to spend at their direction to improve their lives. What happens with ODSP funding envelopes and what happens in the justice system dramatically impact people with mental health and addictions, and we need to start thinking and taking those approaches into consideration to successfully address these issues.

So as I said, the objects are very desirable. They're inclusive of provincial and local needs, they seek the engagement of the community and it's about achieving higher performance through best practices and continuous improvement. But again, these are hospital sector, hospital focused, and health is much more than what happens in the hospital. We need to incorporate systems that reflect broader determinants of health. One of our key recommendations is to develop indicators and policies and implement strategies to reflect community health services and the needs of Ontarians in their local areas.

Included also for you is what is probably the leading thought piece on quality. It's about quality by design and what we know that works. Some 80% of first mergers and amalgamations fail within the first three years, but by taking some of these sort of bullets, these high-level thoughts, and applying them to your processes, you can actually achieve higher success rates.

The importance of leadership and policy: Policy without tools doesn't work, and that's one of the biggest challenges we face. We talk, but we don't implement in the right way to get the results that we want. We have to change that.

Transformation is ongoing. It doesn't stop tomorrow or at the end of this review. It will be ongoing the next day.

Fostering a culture of co-operation and participation: I'm sorry, but it takes time and a lot of strategies to be able to go forward on that.

Be wary of narrow targets. Narrow targets will not work in health care. In mental health and addictions, narrow targets actually defeat a lot of the services.

Just as an aside, in an acute setting, we talk about the contact with the family physician. In a mental health or addictions service, you could have 10 contacts a day with an individual, that are completely necessary for that person to feel safe, to function in their home and to not have to go to an emergency room.

Remember, we always say, “Let’s fix this problem. We’ll get that hip replaced.” In mental health and addictions services, it’s about the relationship you have with clients that supports their independence and their dignity and allows them to be full, functioning partners of our community.

One of the things we know is we’ve had some real successes, but we’re not necessarily always building on them. I just want to flag, when we talk about changing and implementing quality and looking at transformation, some of our great examples in mental health and addiction. For example, the system enhancement evaluation initiative, the SEEL, was one of the first comprehensive pieces of research tied to new investments that were issued by the government of Ontario around specific mental health services. That evaluation showed that those resources worked, for what they were, but they were nowhere nearly comprehensive enough to actually dramatically change the situation with Ontarians’ mental health and addictions. The comprehensive assessment project was another good example.

The MIS compliance project: I cite that because it was a good example of collaboration. We wanted to go to a new management information system for reporting to the ministry and the LHINs. The organizations tried to reach that. Out of the initial pilot, which included about 15% of organizations, only 4% were able to make their first submission. But through a strategic partnership with Addictions and Mental Health Ontario, we were able, within a year and a half, to get that up to about 95% compliance. Again, it’s about the collaboration, the integration, and utilizing the expertise to get those.

As we go further along in today’s presentation, there are a few priority areas that I’m going to be focusing on: accountability, collaboration, system transformation, governance, the Ministry of Health and Long-Term Care and LHINs’ collaboration, and funding.

Let me talk about some of the growth and success in accountability. The three-year multi-sectoral accountability agreement cycle is a success. It’s part of the growth we needed to have so that we could look at targets and start to actually get out of the planning from, often, month to month and year to year in mental health and addictions. We now have a process that lays out, for three years, our accountability and expectations with the LHINs.

Increased emphasis on performance measurement and quality indicators: I’ve heard this criticism many times, that we’re not sure what mental health and addiction agencies are doing. We want to see more improvement in that area. I think the discussions that we’ve been having are getting us to that place. We have a long way to go, but we are making progress.

Some of our attempts at standardized software—for example, what’s happening with the newly announced health links—have been successful. It gives us some consistency from LHIN to LHIN and across the province.

We think there has been a lot of success with consulting on the sector. Our most recent MSAA process has seen a lot of consultation between associations, sector organizations and the LHINs, to get this agreement right.

Back office model—somebody was asking questions on that earlier: Again, you’re going to see as we go through this that sometimes I’m going to highlight successes, but the same problem will exist in other areas.

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Back office has been very successful in areas where we have gone back to what is a high-performing quality system, how you actually integrate services. When you’re using the best practices, you will have much more success in those types of processes. We think because there are too many organizations, and we can save money by bringing our back offices together, we’d get a different reaction and you’d get different results.

For accountability, some of the challenges—I’m just going to start citing a lot of these. Within our MSAA agreements, the variability in definitions, the variability in data collection, the variability in data measurements and on and on and on continue to distort what is actually happening, our understanding of mental health and addictions services, and the results of that. We’re actually in a position where it is very difficult to compare for you, say, for someone in Simcoe-Grey, what’s happening with their mental health services to what may be happening in any other area of the province. We need to get a better understanding of data, the definitions and the data collection systems.

We really need to understand the systems, and this alludes to what I had been discussing earlier about not utilizing the broad determinants of health. The importance of housing in the outcomes of mental health and addictions services is crucial. Without housing, there will not be the success that we all know we need to achieve. But that understanding has been very difficult to build. We have a long way to go so that organizations like the LHINs and, I’d say, the ministry and many other decision-makers actually understand what community health is all about.

Smaller agencies are often struggling to meet the same accountability requirements as large institutions and hospitals. All of us in mental health and addiction want accountability. We want to be able to demonstrate our success. But setting the bar at one level right across the system actually goes to the heart of the matter, because many of these small community organizations and service providers are actually the linchpins in ensuring the success of mental health and addiction treatments. We need to make sure that those organizations are nurtured within this system until we can get to a place where we are a truly integrated health care system. Issues like governance, back office—all of that will start dissipating, but

until we actually value those organizations, I don't think we're doing them any justice within the system.

A really good example of that: I've worked with this family, and 20 years ago, before anyone was really talking about supportive housing in the mental health sector, they bought a house for their son with schizophrenia. Then they opened that house to 10 other individuals. They supported that for many years. Finally, the ministry has stepped up, and obviously, there's funding that's going in, but there's not a lot of value placed on that governance that that family—with a board, not for profit—not a lot of value has been placed on their efforts within the health care system, and that, to me, is really a very big problem.

Often, with our MSAs, our outcome indicators do not line up with our new projects, so we have discussions about indicators and targets, but we don't necessarily have that embedded in our accountability agreements, much like I identified earlier in the legislation. A good example is ALC, alternate level of care. Right now, I know there are 450 people identified with mental illnesses who should be in supportive housing. There is no capacity for that supportive housing in the province.

These people have been languishing in hospital beds. Of that 450, the minimum is six months' time. We have a lot of work and discussion about addressing ALC beds, but because we do not have the political will to go forward with a housing strategy and to expand the availability of supportive housing in the province, we let people languish in a hospital bed.

Sector consultations around accountability: LHIN processes are often rushed, and there's very little opportunity for local providers to have input into those processes, let alone on a provincial basis. Consultations also tend to occur with larger mainstream organizations, not acknowledging the realities of those services working with some of our most vulnerable populations. Communication and rollout plans following public consultations require much more involvement from stakeholders, and also much more communication to our communities.

Further challenges around accountability, on integration: Efforts are often focused on reducing the administrative burden for LHINs. Collaboration and willingness for that integration is often forced. These are where we fail when we go forward. Some 90% of community-based service providers—mental health, addictions, community support, developmental disabilities, autism services—were started by community members, people like me and you, to actually address issues that were not being addressed by our health care system. We have to start actually understanding why that commitment came forward and why people fought for these services and built them and make sure that, as we go forward with our transformation—accepting that this is right; housing is the right way to go—we don't discard that effort and initiative. There's more on that when I get to governance.

Back office and administrative overload: Many of the temps have actually required more training for staff, and trained temporary staff more often. An increased work-

load on fewer people: Even with the back office, your material has to be prepared and presented to be fed into the back office, fed into accountability agreements. The savings haven't been that great. Increased costs onto contracted-out services: Again, we go back to the size of the investment not being equal to our accountability agreements. These back office initiatives can actually be overbearing on smaller organizations.

I wanted to touch on the administration rate. There has been a big push to have a 10% administration rate. Who could argue with that? I think that we can clearly say in mental health and addictions service that we have probably some of the lowest administration rates. The problem is, we continue to compare apples to oranges. I can tell you that, in an acute setting or on a hospital budget, you have a physical plant line, to maintain your building. There is a funding line for that. In most mental health and addictions facilities, that's considered part of administration. The cost of food is a similar type of process. An executive director who may be running a small organization spends 40% of their time on administration and 60% of their time on clinical or support services, their entire time is considered administration. Our system continues to look at what happens in one part of the health care system and try to overlay that on other organizations who really have never had that flexibility within their budget lines and whose data, quality and information systems are not reflecting what services they are providing. It's a beautiful, noble goal to get to 10% administration, one I think we could all embrace or try to get to, but let's actually get to the place where we're truly comparing what our administrative costs are in different parts of the sector.

Accountability challenges on LHIN boundaries: LHINs try to work through saying boundaries are not going to be a barrier to service, but they continue to do that. We know organizations that are serving two to three LHINs. Their funding comes from one LHIN; that's the only LHIN that they are relating to. Despite the fact that they may be providing services across that boundary, there's no interaction.

There's also the tension between local needs and best practices and standards. We will have evolution happening where a LHIN, with the best of intentions, tries to improve access to a service in their community, but through that process, they ignore the fact that that resource may actually be a provincial resource. So they put in blocks for people accessing it from different LHINs.

A good example of that is residential treatment facilities in the addictions sector. Sometimes, people do not want treatment in their local community; they want to go somewhere else where they will have better outcomes. They need to get out of that environment, but as we go forward and see that evolution, we don't necessarily treat that residential setting in a LHIN as a provincial resource. It must conform to the LHIN requirements, putting a block to somebody from Thunder Bay or another part of the province getting access to that service.

Consistency across LHINs: When LHINs were first initiated, I went to every consultation on that front, and I talked to every community service provider who would give me a moment. I talked about this as an opportunity to transform the system and actually get to true community health.

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I believe in meeting local needs and the requirements to do that, but it can't be done in isolation. We need some consistency as to how they operate, how funding decisions are rolled out, what the system priorities are and how we will evolve the system. You can make changes for local needs, but I know that if you go into a withdrawal management or supportive housing project, whether it's in Windsor or in Wawa, you should have expectations of similar outcomes. I think we're seeing too much of a disjointed approach.

We need to look at population health research, and we need long-term solutions, not band-aid solutions. That's part of our challenge. We will get increasing pressure from news and all kinds of other things, and we turn on a dime to address that issue.

Again, I talked about those 450 people in ALC beds. We have all this work going on about trying to divert people out of ER and ALC beds, when really the solution is about getting more supportive housing within the system. It's not going to get you an immediate response; those 450 beds will be filled immediately by somebody else with the same sorts of issues, but we need that concerted strategy to start changing the dynamics, to go from band-aid solutions to actual health solutions.

For accountability, we want to see the three-year cycle of accountability continue. We'd also like to see three-year commitments to funding, including base budget increases so that we can plan as we go forward and that, when we see other opportunities, we know we have a steady base.

We want to see continued consultations and collaboration. I think we've set a tone for this round of the MSAs, and we need to continue to build on it.

We need meaningful measurements of successes and failures of current services. Again, we go back to the minister's action plan, what was given there and what's happening in the 10-year strategy. But by the time we get down to our MSAs, what we may be measuring is not really reflective of our services, but is meeting the other needs of other components within the health care system.

I'm going to move into collaboration and integration. I want to talk about some of the successes—

The Chair (Mr. Ernie Hardeman): Five minutes.

Mr. David Kelly: Five minutes? Okey-dokey. I'm going to go really fast now.

Shared agreements and relationships—these are our successes—have been enhanced, and better networking opportunities. Expanded coordination of service delivery with provider-led coalitions has been successful.

I think there's actually a much better understanding about the requirements of the ministry and the requirements between the LHINs. I think there's a much better

understanding of service providers and how they need to support and integrate that. There have been more education and training funds available, and LHINs have acted as a conduit to bring providers together.

Challenges around collaboration: Recognition of the value of best-practice models in integration and collaboration are required. We keep trying 13 different approaches—there's actually a lot more than that—and we know that 80% of forced mergers fail, so let's go to the best practices on integration and collaboration, adopt that and support that through the system.

Relationship development between providers is needed, and incorporation of change management strategies. We have not actually talked to these community organizations about the need to transform in a meaningful way. It's just, "Here are your marching orders. Go and do that," when there are a whole bunch of strategies that we know will be able to make that a success.

I'm going to skip over the rest of the collaboration recommendations. You can get to some of that in your questioning, I hope. But on recommendations, we need a concerted effort to become actively involved in service- and system-level projects.

Constantly, we're doing all kinds of work on a provincial basis to improve the outcomes of the health care system. LHINs are either under-resourced or focused on other components, so they can't always participate, which means that when we find out the best practice and we want to instill that, not only do we have to go through the ministry, but we have to go through LHINs to get to a place where we actually get buy-in for those types of changes. In a system like mental health and addictions that has been underfunded and underserved for a long time, that is a recipe for disjointed service delivery across the province.

We need better collaboration with provincial partners. We need implementation of evidence-based solutions, standards and best practices, but beyond treatment. We often always just get focused on whether we have access to a psychiatrist. Do we have access to that? We have to start thinking about other solutions.

Do I just keep going here on system transformation?

The Chair (Mr. Ernie Hardeman): Yes, you've got a few minutes yet.

Mr. David Kelly: Growth and successes: We have seen resources, direction and support to encourage utilization of best practices. We need a lot more. We think the development of health links is actually a positive step. It's early days still, but we do see some good coming out of that. We've seen some excellent collaboration on software, and some encouraging of true partnerships that really enhance client-centred care.

Challenges: Some of our partnerships have felt coerced. We need more substantiation of the active use of evidence-based research and best practices. Policy support is lacking in the implementation phase across the system; we have a policy shop and we have an implementation shop, but there's a lot that has to happen in between to get the success on the ground, and we've

seemed to really fall down on that. A lot of that, I think, has to come from our ministry partners.

Often, back offices cost more, and often our transformations have been focused on structures instead of people. I'd like to really recommend that we reverse that and focus on what people need, and not on the structure that's required to meet those needs.

Some recommendations on system transformation: We need clear definitions of the roles of the ministry and the LHINs, and stronger collaboration between all the ministries. Mental health and addictions are impacted by about nine ministries. We actually need stronger collaboration, and stronger collaboration with the LHINs. If we don't understand what's happening in our justice collaboratives and the diversion of people in our court system with serious mental illnesses and addictions, that will negatively impact planning for our health services. We need to get a holistic approach to mental health and addictions.

We need better provincial policy and change management strategies, and we need to better understand the utilization of best practices within that system. We know best practices, but we're not sure if any of the decision-making processes are utilizing those best practices.

Governance—I need to touch on this, because I think it's really important. I think it's been positive; the board-to-board meetings between LHINs and local service providers have never happened in the province before, and that is a very positive thing, but we need governance that allows communities to participate in the shape of the delivery of health care. I think those are positive.

But, on the negative side, where we need improvement is that there's often a view that these community sectors are viewed very negatively by the LHINs and decision-makers. I know; I work with all of them all of the time, and they can be problematic at times, but usually it's problematic because they are unable to address the needs of people accessing their services. We just have to get our heads around how, yes, we have these voluntary boards. We should be unleashing the potential of all of these volunteers—their time, their fundraised dollars—into building a better health care system, and through consultation.

We feel that there's a lack of understanding of the broader health system at the LHINs. The governance model of the boards is not clear, and I think that we need a process to establish representation of the community and broader health sector on LHIN boards. This will lead to better social, economic and cultural aspirations.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. I'm sure the rest of it will come out in the questions.

With that, we'll start with the official opposition.

Mrs. Christine Elliott: Mr. Kelly, thank you very much for appearing for us today and for the work that you've done. I remember you appeared before the Select Committee on Mental Health and Addictions as well, so we really appreciate your input.

Mr. David Kelly: Yes, I did. Thanks for your leadership there, Christine.

Mrs. Christine Elliott: Thank you. You've raised a lot of issues here. Let's start with some of the governance issues. It's rather concerning that some of the LHINs aren't taking seriously the views of local boards. Is that happening, in your experience, across the province?

Mr. David Kelly: Again, nothing is blanket across the province. Ontario is a very diverse place, so there are many different initiatives and approaches. I would say, though, that it has been challenging within that governance in the sense that it's not an equal partnership. Oftentimes a LHIN will end up having to focus on, say, these five large providers within their boundaries. Often, with a larger swath of those community organizations, their voice cannot be heard.

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I understand it in some ways. Look where the money is flowing, how those dollars are held in those systems. So, the LHINs naturally, with their outcomes and indicators, turn to address those funding dollars, even though we know that that community governance is the strength of that system and why all of those community organizations were developed in the first place.

So, is it everywhere? I would say no. Does it depend on the organizations or their service sectors? I would say yes, it does.

Mrs. Christine Elliott: Okay. Thank you. The other issue that's of some concern is the consultation piece. That, of course, was the subject of an Ombudsman's report, that there were many LHINs that weren't engaging in that community consultation. Would you say that that's improved in the last while? Is it something that still needs a little bit of work, or is it still a major problem?

Mr. David Kelly: I think that there have been improvements in that, but I think that we could actually be doing a lot of different things. To my thinking, every organization that is funded by a LHIN, not-for-profit, actually consults continuously with their clients and with their community in a whole bunch of areas.

Again, LHINs, I think, have an opportunity there to utilize that consultation to better demonstrate how they're building the health care system. Actually listening to people with serious mental illness and their feedback on the services or what they need would actually go a long way in strengthening the governance models of both the local providers and of the LHINs.

A simple thing might be, what are the five questions each LHIN would like answered from every annual general meeting from every funded organization that they support?

Mrs. Christine Elliott: Thank you. You talked a little bit about the priorities for the LHINs. Of course, they were set up to reflect local concerns and local priorities, but there seems to be some concern that's been expressed that there isn't a central direction for the LHINs, that many of them are going off in different directions, not necessarily in adherence with what the general priorities of government or health policy are. Are you seeing that in the mental health and addictions side of things?

Mr. David Kelly: Yes, we do, despite, I think, the best efforts of all parties to actually get this right. We didn't come at this from a very strong base. Essentially, I go back to what I had flagged: Our data quality and our functional centres are not necessarily there to start with and are not necessarily reflective of what's going on in the system.

But also, the data are being inputted from different directions, in different ways, because of different historical directions from each of the LHINs. Again, what ends up happening is that when we look at it, a LHIN may talk about its outcomes in one area of health care, but we cannot necessarily compare that to other LHINs, because, again, the quality of that data and how it's been inputted into the system could vary from place to place to place.

A good example of that is often case management. Some LHINs have been moving to a place where you can only have one contact with a client in a day collecting that data, but in reality what we know is that, with some clients, you have multiple contacts on any given day for that individual. People who are showing up in an emergency room on a daily or weekly basis are often there not for health reasons, but because it's a safe, warm place for them to go.

We don't have a handle on how to actually address some of those issues. When you see things being implemented on a provincial basis—a good example would be addiction supportive housing. The government laid out about 12 principles. The LHINs went forward, and we were doing an evaluation of addiction supportive housing.

When the LHINs implemented that, they implemented it in 14 different ways. Some were for very, very valid reasons, to be able to meet their local community needs, but in reality, when we start looking at that, and analyzing and evaluating the services, we cannot tell, because each of these have been implemented differently. The data had been collected differently, so we had all these barriers to jump over to get a picture of what was actually happening.

That distorts all of our planning. If the bad data is being utilized to do our planning, the bad data duplicated will get us different resulting bad decisions across the system.

Mrs. Christine Elliott: Just specifically with mental health and addictions, you talked about the fact that there was a need for greater coordination, given that about nine ministries deal with mental health and addictions—justice, housing and so many others. As I understand it, the implementation of the mental health strategy provincially is now resting as a standing agenda item with deputy ministers. Do you think that's sufficient?

Mr. David Kelly: Bearing on the results, the first year of the three years of the strategy was focused on children and youth—which I think was a good strategy, because we can start downstream and hopefully prevent people from having to access those services in 10 years.

But I don't think that is adequate enough, because I don't think we still have—ministries, like LHINs, all feel rivalries between each other. With how they go forward

and plan, health is the behemoth in the room, so often it's looked to as a resource-rich ministry. I don't think that's actually the best way to run the system, but I think we need more of that all-government approach and actually understanding what's going across.

When we make an investment in human justice and the diversion of people from, say, the court system, then we actually have to look at what that impact is on health services, because individuals who've come out of a court system are going to have different housing needs than individuals who may have had emerging schizophrenia or another mental illness. I think we need more and stronger coordination between the ministries and the LHINs as they make their decisions.

Mrs. Christine Elliott: I would suppose that the lack of coordination among the various industries would have an impact on the decisions that are being made by the LHINs, because they would get somewhat confusing signals about what the priorities should be. Is that fair to say?

Mr. David Kelly: I think that there has definitely been some of that happening within the system. We spent two years developing what we thought would be the top, or an accepted, assessment tool for mental health services in the province, then we had to spend another two years because it wasn't recommended for community health services, but not used in hospitals. We had to get past that barrier.

Everyone wants to rush to the one holy grail of answers. I think that's a mistake. We actually need different tools in the community setting, as you do in a doctor's office, as you do in a hospital setting.

We spent a lot of time on that process to get to one assessment. I was on that committee. We reviewed 127 different assessment tools. We made a specific recommendation to go forward with that. We had to get the ministry buy-in across a whole bunch of different places to have that happen, then we had to go LHIN by LHIN by LHIN to get that implementation to happen.

Eventually, we got that. We're at about 85% implementation now, but, again, you would think that if you're going forward to develop assessment tools on a provincial basis—and we have some really good ones coming out for the addictions sector, which I hope to see implemented soon—if you have to do that work and you have it on a provincial basis, and you've had the experts come in, then that tool needs to be implemented, and it takes all the LHINs and the different ministries to implement that tool. That, I think, is where we could do a much better job.

Mrs. Christine Elliott: Thank you very much. Those are all my questions for now. I think my colleague has some questions.

The Chair (Mr. Ernie Hardeman): Ms. McKenna?

Mrs. Jane McKenna: Thank you so much. There's lots of information here, and I appreciate you being here. In all the time that you've been dealing with the LHINs—how long, actually, have you been dealing with them yourself?

Mr. David Kelly: Myself?

Mrs. Jane McKenna: Yes.

Mr. David Kelly: Okay. As a provincial organization, we were initially funded by three different LHINs. We were bounced around, and are now funded through the Ministry of Health. But I am very pleased and proud to say that I am able to work with the LHINs on many different projects and strategy tables, so I have a lot of interaction with the LHINs on a provincial basis.

Mrs. Jane McKenna: And how long?

Mr. David Kelly: Sorry. Well, I started before they even had the name of LHINs.

Mrs. Jane McKenna: Okay, so seven years ago.

Mr. David Kelly: For their entire lifetime.

Mrs. Jane McKenna: Okay. And how has your relationship evolved with them over that time?

Mr. David Kelly: Again, I think it's been up and down. There have been many challenges in working with the LHINs. We've seen huge, incredible amounts of turnover on staffing and leadership within the LHIN envelope. When you lose that leadership, you often end up starting at base one. It takes them a little while to actually even understand what is happening within their health system.

I would say we have seen a steady improvement. I go to the most recent MSAA negotiations, and the provincial MSAA table that we've just gone through. Whereas the first round was actually consulted through in July, and we had to provide final answers to the LHINs by September, we've had a much more successful process now: greater interaction and more willingness to look at changing these to make it more reflective of the sector; it's not been as rushed. I think with the maturing of the LHINs, we should be able to see the maturing of that relationship.

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Mrs. Jane McKenna: I didn't realize there was a big turnover and then a leadership change, so that's news to me today.

You being the constant there, I think one thing that we have noticed, being in here, is that it's the performance of what one person is doing to the next, the silos and giving the information from one to the next, and actually not doing that. What would you say the biggest challenge is, besides the leadership and the turnover?

Mr. David Kelly: One of the biggest challenges is the disjointed approach of the many ministries involved in mental health and addictions, and the LHINs as their processes.

Understand that it's just in the last few years we've had the recognition that we need to start addressing our mental health and addictions concerns in the community. You have organizations in a system that has been over on the side of health care—and no offence to any of my colleagues in the acute sector. Any of that—heart attacks, babies and cancers—drives and has driven health care, not necessarily the need to build the community resilience to address individuals' mental health and addiction needs.

What I'd say is, we are just showing the approach with the best of intents to address multiple issues, but not actually getting a focus to have a direct impact across the province. We have the meeting of local needs or we have pots of investment that come out that then are not necessarily utilized in a similar fashion from LHIN to LHIN.

If you look at any high-performing health system or any high-performing regional system, the basis of that system needs to be the standards, the best practices and the funding mechanisms to actually build that system. What we had is a process that came and overlaid LHINs to replace regional offices which were doing similar work beforehand, but not as in-depth—had them overlaid without the base of standards, best practices etc. in the community mental health and addiction system, I'd say, almost in all community service provision. We have those for the health system so we can actually start getting to measure in the acute systems, so we can go to those measurements—or within community care access centres, where they've spent lots of money to get to those types of data collection systems and measurements of those systems. But when we come down to mental health and addictions, those investments have never been made.

So what is a standard—again, I'll go to case management. We have different variations in the standard of case management, anywhere from a 1 to 8 ratio to a 1 to 12, 1 to 20, 1 to 100, because organizations have picked up the slack and have addressed every need that's coming to their door. Without actually having a clear understanding of what it takes for intensive case management and what the number of clients should be or the severity of those clients in a case mix, we don't necessarily have all of those in place.

I'd also say that the ones that we've had have never been able to be kept up. So as you see the release of funding—I'll use case management again. An existing case management position was funded at a much lower level than new case managers added to the system. All that means, then, is you're robbing Peter to pay Paul: You can't hire staff and pay them at this higher salary with the same qualifications; you have to water down that money to keep all of your staff at a similar type of level. But when you go into the community sector, you can have people doing the same job—and I know of places where they're sharing offices and desks—and an acute or a hospital provider staff is being paid 30% to 40% more than that community setting service provider.

Mrs. Jane McKenna: Do you think too, though—you made a very valid point there that having a baby, a heart attack—I can't remember the other one you said—

Interjection: Cancer.

Mrs. Jane McKenna: Cancer, sorry.

Mr. David Kelly: I don't mean to be derogatory, believe me.

Mrs. Jane McKenna: No, no. I'm just saying that those things are immediate things that you see right then and there. I did my white paper on children and youth, and it is a systemic problem and it is one band-aid after another. When you look at one person going through

their lifetime—I could be incorrect with the actual data right now, but I think it's \$1.4 million from beginning to end, in and out of hospitals, doctors, jails, whatever those situations are. Do you think it is because it's a situation where we don't—right at that immediate second, there was some result that you could have taken?

Mr. David Kelly: It's two things, and it absolutely is because we don't see immediate results from the services that we provide. As I said, working with that client, say, 10 phone contacts or 10 visits from them in a day actually may be exactly what that person needs to keep them out of the emergency room that evening, but it takes special relationships and to be able to utilize those relationships to get those results.

But a broken hip, for somebody without a serious mental illness or addiction or without isolation problems, we can then say, "Okay, we'll fix that broken hip. Six weeks later, you're going to be fine, and we can know we can discharge you."

In mental health and addictions, and I say this—because I don't like to be self-serving; I want to be able to think about building better and healthier communities. I think that is crucial. So if we don't link, say, children's aid societies, where we know that 60% of those kids will have a serious mental illness or addiction in their lifetime, if we're not building resiliency with those kids, we are just creating future customers for mental health and addiction services. We need to actually link those systems with health care and vice versa to be able to get to those better results. This is not easy work.

Any of us all know we've been impacted by mental health and addictions. It sometimes takes four or five times in a withdrawal management program before you can actually get to the core issue, and trauma—we're just getting to understand that.

We spend all this time and effort on trying to get homeless people off the street or addressing these issues, and in reality, most of that is the result of childhood traumatic experiences. So we will move heaven and earth to get that kid into a safe place, yet we will go to a model of ignoring or punishment for the adults who are the result of not being saved from that childhood traumatic experience.

Our understanding is changing daily in mental health and addictions, and we need a system that can help transform in that type of way.

Mrs. Jane McKenna: I'd like to just also say a couple more things. In the kids that are awarded to the crown, 70% of those children go out into the streets. It's a massive—it was heartbreaking and saddening when I got that information myself.

I want to thank you very much for coming in and for continuing to put us in a place where we definitely need to go. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much, and that concludes your time.

The third party: Ms. Gélinas.

M^{me} France Gélinas: Hi, David, and thank you for coming. I always admire your in-depth knowledge of the

mental health and addictions system and how you can share this passion when you speak.

I want to bring you back to the reason why we're here. We're here because we're looking at a review of the LHINs, and I will put my question to you in a minute, but I fully understand that if we are to help people who have addictions and mental health problems—we now have a system that deals with nine different ministries. That system is disjointed. I fully understand that Housing First is there. If you don't have a safe home, nothing else matters. You're not going to be able to work on your addiction or your mental health. You need a place. And incomes matter and isolations and stigma and the justice system, and all of this.

So help me understand how adding a layer of bureaucracy called the LHINs actually helps your system, and let me finish before you start answering. If I was to be serious about wanting to integrate and do the work of the LHINs for the mental health system, I wouldn't put that under the Ministry of Health; I would put this in a place within the government that has access to all nine ministries.

I know that the funding some of the members of your associations get from their LHINs is actually a pretty small part of what they do. They get funding from six, seven, eight different sources to do the great work that they do, and the part they get from the LHIN, frankly, sometimes is considerable, and sometimes not so much.

1710

We are here right now, looking at the act. Mental health was put into the act, which is why the agencies that get financing from the Ministry of Health now get it from the LHINs, with their accountability agreement and their MSAA and all of this. I fail to see how this could help the addiction and mental health system.

Mr. David Kelly: I think the first thing is that all of us, as part of our submissions to the select committee—the 10-year strategy actually called for a focus on mental health and addictions that could cross all of those different ministries. We cited the example of Cancer Care Ontario, that has transformed cancer services in the province.

What we do actually need is that type of specific focus that can go across all of those components of the government of Ontario, and then translate that through good policy and implementation to the local health integration networks. What we end up getting with the disconnect is, we talk about the need to reduce emergency room visits, and that is implemented, but it doesn't necessarily implement in a way that addresses some of the core issues, because we go back to our indicators and our outcomes and that type of discussion.

No matter what, within the health care system, we do need administration. I firmly believe in accountability, and I think that the LHINs have actually demonstrated that they are trying to work that through. The LHINs are essentially in a box themselves, because they are boxed in around health care and those services that are funded by the Ministry of Health. That's where I think the failing

is, because it does not take housing into consideration. It does not take into consideration those other actions or services of the ministry, because that's outside of health.

When you look at these organizations, I'm really proud, honestly, to say, "Look at all these community-based services that get this much funding, literally this much funding, from the Ministry of Health." But that little bit of funding actually sets the base for the organization and it starts leveraging other dollars, because they're legitimate and they receive Ministry of Health funding. That leverages United Way dollars. It leverages other funding dollars. It may leverage federal dollars. Those organizations piece that together to provide quality services in their community. It's not the way a system should be functioning.

M^{me} France G  linas: I fully believe in regional planning, and I, with you, support more accountability and more robust transparency. But you have not convinced me that having mental health services under the LHINs is the way for the mental health services to meet the needs of Ontarians.

I was on the Select Committee on Mental Health and Addictions. Our number one recommendation was to create what we called, at the time, Mental Health and Addictions Ontario, which would basically—

Mr. David Kelly: The name is taken now. Sorry.

M^{me} France G  linas: Yes. You put it in alphabetical order; we didn't.

But the idea is really, to me, you would be so much better served in a regional model that is not under health but that is under the government, that is able to connect with all nine ministries provincially, and that funds and that has a direct impact on services, the first one being housing, the second one being ODSP payment, the third one being—but health would certainly not be the top one. It would be kind of seventh or eighth on my list. But health is the one that has the bucks, and I get that—\$48 billion; it stands out. If you get 2% of \$48 billion, it's way better—I get that. But that doesn't bring us to a highly performing mental health system that actually achieves goals of supporting people.

Mr. David Kelly: France, when you're thinking of this in some ways, it's about how you want to define individuals. Are individuals actually their illness? I understand why we are with the LHINs and that, because the barriers to people with serious mental illnesses and serious addiction issues have been so great in them accessing any ancillary—any of the other health services.

Some people call it stigma; I usually call it discrimination. People, because they have a mental illness, will be sidelined in an emergency room where the health protocols are that they should wait and they will decompress, and then they'll either go or we might be able to do some services. Right? I like to think of people much more beyond what their immediate health issue is. I think that's why we need to be connected through all of the health systems so that we can actually facilitate the access for individuals and for other vulnerable populations to get to those services.

I always get concerned, because we've been hived over on ourselves before. We've been marginalized and ignored within that. Not being linked to the full health care system would make me a bit nervous in the fact that it's much easier to ignore mental health and addiction issues when it's not right front and centre in the room. That's where mental health and addictions need to be. They need to be front and centre in every room in the province so individuals who are accessing can connect to all of those other services and supports that they need.

M^{me} France G  linas: Do you really have hope that the LHINs, at some point, will care in a meaningful way about income, housing and social determinants of health specific to the population you're trying to help?

Mr. David Kelly: I thrive on hope, France. We have to be able to do that to function in mental health and addiction services and, I'd say, in community services. You have to understand that you're working with some of the most marginalized and hard-to-serve people. What gives you hope is seeing the success of those individuals when they get access to stable housing, when they get the right health care, when they get connected and when they have a living income. You can see the results and you can see functioning people. We've had members of Parliament who have been able to get there because they had their total health, their total experience as a person, addressed.

Just to answer you a little bit further, I was a member of the minister's 10-year strategy. The most important facet of that strategy is building community resilience. If we are not addressing and building that community resilience—it's from everywhere, from a local sports team and arenas and hockey—we will not have a good health care system. Part of the challenge here has always been that the health system has been focused on those acute needs and the band-aid solutions, the operation, and not on building the resilience within their community. What I hope to be able to do is help build that resiliency. So, yes, I still have that hope.

M^{me} France G  linas: But that will happen beyond the LHINs. So what you're saying is that being under the LHINs means that you are not forgotten by the health care system, which is very easy for your sector to be—the poor cousin of the poor cousin doesn't get invited to the wedding too often—but at the same time, in order for the system to thrive, most of the work will be done outside of the LHINs.

Mr. David Kelly: Again, I go back to building that community resilience. We need to tie those pieces together, and so many—

M^{me} France G  linas: But the LHINs are not tasked with building community resilience.

Mr. David Kelly: I hope that some of the result of this LHSIA review is that we either task the LHINs with going forward with that or we strengthen the ministry implementation role in setting those provincial directions and we task the LHINs to be able to do that. But understand that no one organization is going to address that.

We used to have other mechanisms like social planning councils etc. around the province that could help

support that. I think that we need to connect all of those pieces to be able to do that. My fear is that by taking it, say, out of health—because we've had this discussion. Many of our services were in Comsoc, community and social services, before that. We wanted out of there to be able to make sure that mental health and addictions were addressed right through the health care system.

M^{me} France Gélinas: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Okay. Ms. Forster?

Ms. Cindy Forster: How much time do we have left?

The Chair (Mr. Ernie Hardeman): Eight minutes.

Ms. Cindy Forster: I'm actually going to give you my time so you can finish your presentation.

Mr. David Kelly: That's very nice of you. I'm not sure where I left off.

Ms. Cindy Forster: I think that's much more insightful for us.

Mr. David Kelly: Okay. Thank you. I'm going to just sort of go back—

The Chair (Mr. Ernie Hardeman): She should have given you that notice ahead of time.

Mr. David Kelly: Yes, and then I could have actually found my spot. I was ready for another hard question.

1720

I'm going to go back to some of the—I really started rushing when I started getting into collaboration and integration, so I'm going to go back there and start. Just let me know when my time is up.

I flagged some of the growth and successes: the shared agreements and relationships between providers; enhanced networking opportunities; expanded coordination of service delivery with provider-led coalitions.

The reason I said “provider-led coalitions” is because wherever you have seen failures has often been the overlay of new ones. LHINs that have utilized those provider-led coalitions and existing infrastructures within their local communities have had more success in getting collaboration.

I said that one of the positives that has come out of it is that there has been a lot more understanding of LHIN responsibilities, requirements and reporting relationships with the ministry and local service providers. This is more than has ever existed before, whether it was in a regional office or—so now I think there's a broader understanding, even by these smaller community organizations, of what pressures may be on the health system and how they need to better support that work.

When we get into the challenges, it's again—a bit of a theme in my presentation, I guess, is the recognition and the value of best-practice models and integration and collaboration. We need to go into that area to actually get to a place where we can understand how to bring community services together.

Even the relationship development between providers needs to be strengthened because, again, we often are going to those larger provider systems, or providers within them, and many of the smaller ancillary groups.

For example, France was saying that if we had LHINs bringing together, as they do on governance with health service providers, and actually having those discussions with those other organizations within their communities—but right now, LHINs are hesitant to go in that direction, because it falls outside of their purview in health.

Even making sure that they take into consideration that we have stronger, more robust consultation processes, so that it's not just focused on, “Here's a meeting; I'll meet with five hospitals and 10 community providers, and that will be our consultation”—it may be that perhaps the minister needs to be much broader, including children's aid societies, social planning councils etc., that that's a possible way to get to some of the issues.

Engagement of service and system-level projects to facilitate learning and aid in knowledge translation: Again, often, I can tell you we've had several projects where we've gone ahead and done massive amounts of work but have not been able to engage LHINs within that process. The mental health leads and addiction leads of the local health integration networks, I presented to them probably four times, three times, over the course of the existence of LHINs, and I think that those types of discussions need to be strengthened. We can't have every CEO on every phone call, but at least getting the LHINs and their mental health leads to have much more interaction and much more involvement on provincial partners would be viewed as a success by our organization.

I don't want to be self-serving in any of this, but there are resources on the provincial base level that need to be utilized in a more cohesive way by LHINs. There's a lot of strength, energy and work that happens on a provincial basis with an organization like Addictions and Mental Health Ontario that actually is speaking to LHIN agendas, speaking to ministry agendas and actually could be utilized to support resources.

For example, we just had a very interesting Trillium grant and created a tool with CMHA Ontario and our other partners, the Association of Ontario Health Centres and the Ontario Community Support Association, on integration. It's a comprehensive tool, a website, all available. It tells you all types of integration. It gives you where LHINs are going, where the federal government is going, where provincial governments are going. It's a fantastic tool. But actually trying to get LHINs to recognize or even take the time to look at that type of tool or participate in the discussion or the development is always challenging.

On collaboration, we want to see more implementation of evidence-based solutions and standards and best practices, and this is beyond treatment. Housing can have as much of an impact on ER usage or be a successful conduit for diverting that, but we need the best practice standards.

I'm going to go to system transformation and growth, and I'm going to go to the challenges there, because I think I really ran through that quickly. You can see the

successes on the slide before. I touched on the coerced partnerships. Often what we've seen is, "Oh, this is a good idea if you form a new organization." So when your funder tells you this is a good idea, whether it is or not, or whether your community organization, which could be two hours from the other community organization—whether or not you should have the same governance structure or whether or not you should be actually as one organization—it's not always the best process.

I want to touch on back-office efficiencies. One LHIN, I know, went through and did a study, looked at their 60 MSAs and determined they could save approximately \$200,000 by going to back-office efficiencies, which sounds like a lot. I'm telling you that's like probably eight staff in the community sector, so it sounds like a lot. But what they didn't go on further to explain was actually that that \$200,000 came from 54 organizations, to the tune of about \$3,000 to \$4,000 savings for each individual organization.

Now, you could have a process where you pay your staff less, I guess. That's not usually very successful. You then have to find that money or that process within your organization, and the lessening of work is not that great, because, again, you have to prepare all of your submissions, everything, for even the back-office efficiency.

Now, it does work for HR, human resource recruitment, but again, this is one of the biggest challenges in our sector, because what we've seen is the installation of family health teams, and family health teams were able to get access to mental health workers—all very good and positive, but what it did is take resources that were desperately needed in the mental health sector and put them on a family health team where they paid their staff more and essentially recruited the staff from the existing mental health agency.

A more comprehensive approach would be to actually say, "Great. This family health team or these health links"—which we're doing with health links—"need mental health support. They need to contract with their local mental health provider to be able to do that work." That provides a stronger base for that organization. It links them with primary care, and you don't have a mental health employee or staff person working alone in isolation; they're actually working within a broader system, and you leverage all the good things that come out of that type of collaboration.

The Chair (Mr. Ernie Hardeman): Okay. Now, unless the government side wants to do the same, we'll go to the questions.

Ms. Helena Jaczek: Yes. I would prefer to ask questions. Thank you, Mr. Kelly, for coming.

Just to start off and to be really clear, and I know you put it literally on page 2 of your presentation, Addictions and Mental Health Ontario: You represent 280 mental health and addiction service and support agencies across Ontario. Do you represent also the four psychiatric hospitals? Are they members?

Mr. David Kelly: Two are members of the association.

Ms. Helena Jaczek: Interesting. Which two?

Mr. David Kelly: Sorry. Let me be clear on that. CAMH is a member, Whitby—

Ms. Helena Jaczek: Ontario Shores.

Mr. David Kelly: —Ontario Shores is also a full member; Waypoint has programs that are members of the organization, and the Royal Ottawa, for example, is becoming a full-blown member.

Ms. Helena Jaczek: So, in other words, you represent the community sector as well as the acute care side?

Mr. David Kelly: I'd say we represent the full continuum of care within the mental health and addictions system, and I would say we're also a bit of an anomaly in the sense that we have many hospital-based programs within the association. But it's always been clear, even within an acute or hospital-based setting, that mental health and addictions have been always marginalized services. Throughout the 1990s and early 2000s, when there were any cuts in hospital services, the first place they would often land is with those mental health and addiction services.

So essentially, we know that there is no health without a full continuum of care, and our organizations have always found and felt that by collaborating right across that full continuum, we will have better results for people with mental health and addictions.

1730

Ms. Helena Jaczek: Okay. That's useful to know, because then I assume that all your wisdom that you've imparted to us does reflect that continuum of care and the concerns across the continuum.

I know at the very end of your presentation, on page 32, you talked about the strategic partnership with the Association of Ontario Health Centres, who of course we've just heard from, and the Community Support Association, which seems like an excellent idea as you're trying to obviously influence so many different aspects of care, as you've alluded to, and supportive housing and everything we know that's so important.

You know that Adrianna was here and presented the findings—

Interjection.

Ms. Helena Jaczek: And is still here. It will be easier for the traffic later, Adrianna. You heard her recommendations. Would you say that your association is, in general, supportive therefor?

Mr. David Kelly: I think we do collaborate and we are very similar. Understand why we came together as Community Health Ontario: It's very important because our voices would never be heard in the health care system. It's actually about strengthening that community voice on a whole bunch of different levels. In general, yes, I would say—I haven't gone through their presentation and I did not hear her actual presentation, but in general what we want to be able to do is, knowing that in all of the communities across Ontario we have community support service agencies. We have mental health and addictions agencies. Some places we have health centres, and we can only strengthen our health care system through our

collaboration and through working together. We're going to have better outcomes for all of those vulnerable populations, whether they're accessing a health centre or a mental health agency or community support through our provincial leadership and communication and dedication.

Secondly, what's also very important is, the health care system is full of very large voices and many, many small ones. Some of our issues actually cross all of those boundaries. The one example I used about family health teams hiring mental health providers is a perfect example. HR is an issue that *[inaudible]*. So we need to amplify our voice to get this to happen, or else we will be back here in 20 years talking about how to fix this system again.

Ms. Helena Jaczek: Well, this is the first I've heard of Community Health Ontario, and I would urge you to consider approaching the public health sector because a lot of what you're talking about, in terms of determinants of health, is very much what public health has always said.

As a former medical officer of health, obviously I think you're absolutely right. The community health sector needs to have that strength, and the more voices you have in a combined fashion I think would be very helpful.

A lot of what you had said is in fact very similar to what we heard from the Association of Ontario Health Centres, and one of the areas was the issue of the indicators, that 14 out of 15 are acute care focus. Have you had the opportunity to consider some indicators that you would like to see as part of this?

Mr. David Kelly: Yes.

Ms. Helena Jaczek: Like some concrete examples—

Mr. David Kelly: I would say to you, I'd like to actually think on that a little bit more on time because this is a legislative level, and I know we've been in a lot of negotiations and LHINs are listening and trying to hear what we are saying about that. I'll tell you, an example I always go to is housing. If somebody is presenting in a homeless shelter because of the lack of housing, and that was public housing in some fashion, then we have an indicator of a failure of a housing project. It's the same as an individual showing up at emergency rooms. If they are attached to a case management program, then some real questions should be asked about that case management program and how it is functioning.

So when we're looking at these and thinking on that, just starting to talk about—I'd have to actually really think about what sort of indicators there are, and I'd be happy to do that, to give you some.

Ms. Helena Jaczek: I think it would be well worth it. I'm thinking of wait-lists for supportive housing, wait-lists for addictions programs, you know, this kind—

Mr. David Kelly: You see wait-lists in—thank you for giving me that because that is actually a perfect example. But I will flag to you, though, as we have transformed—and mental health and addictions agencies are embracing this transformation and integration—we've been developing all kinds of coordinated access programs. For example, in the city of Toronto there's CASH.

Ms. Helena Jaczek: We heard.

Mr. David Kelly: Now unfortunately that started about four years ago with 1,200 people on the wait-list; it just hit 6,900 three days ago. It would be great to have those types of indicators, but we actually need a concerted effort to understand the capacity of existing mental health and addictions services, which I don't think anyone has ever looked at—"What is our ability to respond in our community?"—and then look at where we need to go, because it is only going to be up, and that gets to, like, population-based health planning. But we have to actually start at what our capacity is to begin with.

Ms. Helena Jaczek: That was exactly what I was going to ask you: What would be the capacity to populate those indicators? Because actually, I've been trying to find out what the addictions and mental health services in York region are—the agencies, the addresses, their funding from the Ministry of Health, the patients served and the wait-lists—and I am still waiting.

Mr. David Kelly: Just so you know, we were doing an evaluation of addiction supportive housing. We had to go to three different places to find out who those providers were. One was the Ministry of Health; one was each LHIN; the other was ConnexOntario, which is our information referral system. Then, eight months later, we still actually found programs that were just coming online or that were providing the services and did not report to LHINs. Again, nobody has that comprehensive understanding.

Ms. Helena Jaczek: So it's a bit of a dilemma. I understand why you want those indicators, but I'm really worried they're not going to be able to actually operationalize that.

I guess there are four of us here who were signatories to the Select Committee on Mental Health and Addictions's recommendations. I guess what we're being urged by you and by the Association of Ontario Health Centres to look at is an expanded mandate for LHINs—in other words, bringing primary care within the purview, and certainly some of the human resource planning; we heard about that earlier today. I guess I have a little bit of a concern. In our deliberations as a select committee, we did all endorse the concept of Mental Health and Addictions Ontario because of the multi-ministry involvement, and the way to actualize a successful plan would be to have all those components together: the justice piece, the supportive housing etc.

So I guess we're potentially looking at a choice, here: Do we build on this regional model that we've created, which is the LHINs, or are there some areas which might not necessarily be appropriate to go into?

I would say we know that the LHINs to date are still struggling with the mandate that they have, even the long-term care and the acute hospital piece. To me, they haven't fulfilled that whole piece of it. I suppose the immediate instinct is to say, well, should we really move forward? I think we've heard good arguments and good rationale, but there's sort of a practicality. If they're struggling with the pieces that have already been given to

them, and especially in terms of consistency, community engagement and all the good things that should be a part of that, I guess it's hard to suggest expanding the mandate at this point in time. How do you react to that?

Mr. David Kelly: What I would say is you're absolutely right that there is a lot of work that needs to happen within the acute settings and within long-term care before we're actually—and this is, I think, part of the challenge and why I would say that, often, community services are set over to the side, or, "We'll get there as soon as we fix over here." I think that has been one of the biggest challenges for the LHINs going forward.

Again, you alluded to the select committee. Some of our recommendations and our advice to you at that time were about creating that provincial body, but I think that body—again, it's to balance that local need. I think there is real success in some local planning, but that organization should be supporting the LHINs and making sure, as they go forward with local implementation, that they are meeting what we know are best practices and provincial standards and the data quality that we need. I think you can actually have that mechanism and provide the support to the LHINs to be able to then better focus on some of the other challenges that they may be facing around primary care. I don't like to talk about primary care because primary care is actually primary health care, and it's about a lot more. But when we have discussions on primary care, it often focusses on physicians and physician services.

1740

I know, for example, we have lots of sessional fees that return every year to the LHIN, then to the ministry, because we cannot get access to psychiatric care. Last time we looked—this is a couple of years out of date—92 of the psychiatric programs in acute settings had barriers for people to access them: whether they lived in the community, whether they were referred by one of the residency psychiatrists. Those are issues that have to be fixed up.

We see millions of dollars returned on sessional fees and not used for other components of primary health care, like an RPN clinic or other services. We need more flexibility from either the ministry, OHIP funding envelopes or the OMA agreement to better allow LHINs to apply those dollars that will have an impact in their community.

Ms. Helena Jaczek: Okay. Then you see that there is still a potential for a Mental Health Ontario that would potentially coordinate activities, give advice to individual LHINs, have some sort of oversight of the whole system locally. So you could have both.

Mr. David Kelly: Exactly, yes. In reality, again, the issues in mental health and addictions and in other components of any vulnerable population are very complex. It's not just the health silo that will fix that; it requires those other components. That could be the strength of a Cancer Care model for Addictions and Mental Health Ontario.

Ms. Helena Jaczek: Okay. Well, that's useful. Thank you.

Now, you did talk about your three-year multi-sectorial accountability agreements. I guess this gets back a little bit to the funding side. We did hear some recommendations in the last couple of weeks from some of the deputants that there should be the ability to hold over funds from one year to the next. Would you also see that as being an advantage? If funds are not used in one fiscal year, as you say—perhaps you're developing something and the next year, you want to put in a nurse practitioner-led clinic or whatever new initiative that might come out—that that be a possibility within—since you have the three-year agreements, it would seem that you might be able to have funds over three years.

Mr. David Kelly: Yes, and that would absolutely be the flexibility from all kinds of different levels, right from your planning level at the LHIN down to the local community organization. You'll often have the implementation of a program midway, "Here's your funding," and obviously, organizations—and this is right across the health care system—rush to spend that money as opposed to looking at where they could get the best bang for their buck—also, to look at where the collaboration is to help expand that program, to make it more inclusive and involve those other components that you know need to be there.

So I would say, yes, LHINs should have that ability. But I would also say to you, community-based service providers should also have that ability within an accountability framework so that they can actually utilize the dollars in the best fashion for their community.

Ms. Helena Jaczek: And to do a little bit longer-range planning, presumably.

Mr. David Kelly: We were very pleased to see a three-year accountability agreement because it does help us start setting the course. Again, mental health and addictions and the transformation of the 10-year strategy came in the worst economic crisis. What we've seen is a lot of initiatives to contain and control costs.

If this was the best of times, I would probably be here recommending to you that you need a concerted effort to contain your costs, but to expand investments, sort of a two-way track: Build a community sector so it can take on the role that we all know it needs to have before you start reducing costs in other parts of the sector—which almost requires the government to have an investment strategy in those community-based health services, and I want to acknowledge that we've seen that commitment from the Ministry of Health, saying that the sectors would continue to see an increase in funding—addictions and mental health, community support services; health centres, I believe, were also a part of that.

That's the kind of process we actually need to get to so we can build those organizations. Too many times, I've heard LHINs say, "We need to do this, but we need to do it fast," and we don't have the infrastructure or the knowledge within the community sector. This has been ongoing for 30 years. The investment is taken; it's given

to the same players that have always been funded. It has not allowed that sector to grow in a way to support the health care system and actually be the health care system.

Ms. Helena Jaczek: How much time, Mr. Chair?

The Chair (Mr. Ernie Hardeman): You have about three minutes left.

Ms. Helena Jaczek: Do you have any final words of wisdom for us?

Mr. David Kelly: I think what I would say to you is that with this rollout coming of years four to 10 of the mental health and addictions strategy, we need to really make sure that we're getting this right. It's about the full continuum of care. It's about all of the services outside of health funding. We need to get better coordination to have the best impact on individuals.

Ms. Helena Jaczek: I think that's all. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. If there are no further questions from the government side, then that concludes the presentation. We thank you very much for your indulgence in being here this afternoon and helping us out with a lot of the issues.

Mr. David Kelly: Thank you very much.

The Chair (Mr. Ernie Hardeman): To the committee, that also concludes our hearings. We do have a few minutes in camera so that we can deal with scheduling for the other meetings for tomorrow's committee.

Ms. Helena Jaczek: Mr. Chair?

The Chair (Mr. Ernie Hardeman): Yes?

Ms. Helena Jaczek: Could I ask—perhaps it's the Clerk—who else is scheduled to appear before us? We had long list of associations, and I'm wondering when we're going to hear from the Ontario Hospital Association, the Ontario Medical Association and the other organizations.

The Chair (Mr. Ernie Hardeman): That will be part of the next meeting.

M^{me} France Gélinas: I guess they want to do it in camera.

Ms. Helena Jaczek: You want to do that in camera?

The Chair (Mr. Ernie Hardeman): Yes.

Ms. Helena Jaczek: Oh.

The Chair (Mr. Ernie Hardeman): We have a list here, but it would part of how the committee wishes to set up the hearings.

Ms. Helena Jaczek: Okay.

Interjection.

The Chair (Mr. Ernie Hardeman): Yes?

Ms. Cindy Forster: Could I suggest that we be provided with a copy of the select committee's report on mental health services to read in conjunction with all of the other materials—from 2010, I believe, right?

Ms. Helena Jaczek: Yes, August.

The Chair (Mr. Ernie Hardeman): Okay. That note is taken and you will get that.

Ms. Cindy Forster: Thank you.

The Chair (Mr. Ernie Hardeman): Okay.

The committee continued in closed session at 1747.

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STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 10 December 2013

Mardi 10 décembre 2013

The committee met at 1617 in committee room 1.

COMMITTEE BUSINESS

The Chair (Mr. Ernie Hardeman): We will now start the meeting of our committee. The first item on the agenda for the Standing Committee on Social Policy of December 10 is the subcommittee report or the report that we prepared at the last meeting, which the committee has. There are a couple of other items that we need to add to it, such things as the length of time the sittings will be. So if we could have somebody tell us what it is you would like the length of the day—what time do you start in the morning?

Ms. Helena Jaczek: Yes, thank you. I think the suggestion was 9 to 12 in the morning and 1 to 5 in the afternoon.

The Chair (Mr. Ernie Hardeman): Okay. Nine to 12 and—

Ms. Helena Jaczek: And 1 to 5, except when we combine London and Kitchener–Waterloo. The suggestion was to start a little earlier to give more time to London. So 8 to 12 and then 2 to 6, and then we'll definitely need a good dinner.

The Chair (Mr. Ernie Hardeman): I would suggest that the time for the split day, that we change it to half an hour. We want similar lengths in the two stops: 8 to 12—you said 8 to 12?

Ms. Helena Jaczek: Yes. That was the suggestion.

The Chair (Mr. Ernie Hardeman): Oh, okay. That's fine. Eight to 12 and then from 2 to 6. That would be four hours for each one. Is that suitable? Everybody happy with that? Okay.

We need a deadline for written submissions. They would not be equated to any single presentation or any of our locations, so you could put the written presentations at the end of the tour, if you like. It gives everybody as much time as they could possibly want, because the committee would not need those submissions until the tour is finished—in fact, maybe a long time after the tour is finished. So I think it's just to put a deadline on that when we finish touring, the written submissions must also be there for the whole package.

Mrs. Christine Elliott: Sure. Perhaps if you just make the last day of hearings the deadline for submissions.

The Chair (Mr. Ernie Hardeman): Okay, the last day of the hearings.

Ms. Cindy Forster: The last day of the hearings would be February 11?

The Chair (Mr. Ernie Hardeman): Yes, that would be the 11th of February.

I think those that we've added complete it. If the committee would agree to this—yes, France?

M^{me} France Gélinas: I don't know if it needs to be written down, but let's say we have made the decision to travel to a site—because we have six—by Friday, January 10, but we have openings where we don't have a full day and more people ask to present, would we be open to first come, first served? If people are late but we can accommodate them, I would much rather we accommodate them than turn them away. If the roster is packed: "Sorry, you had a deadline to respect." But if the roster is not packed and they've missed the deadline, especially if they are either a community group or people who are not used to what we do—organizations know how it works, but Mrs. Smith from Kitchener–Waterloo probably has never done it in her life before. We could show a little bit of leniency if our schedule allows, and that would be first come, first served.

The Chair (Mr. Ernie Hardeman): Yes, I think the committee can make the decision when we get there, if there are openings and there are people there willing to present. But I think it's somewhat unfair to say that we will have a process that when we get there, if there's an opening, somebody in the room gets it rather than—

M^{me} France Gélinas: No, not once we get there; if they apply past the deadline but before the visit. They still have to apply.

The Chair (Mr. Ernie Hardeman): I think that was in my suggestion that it's on a first-come, first-served basis. If there are more applications than there are people, then we have to have a process of defining the list of those who get to be heard, and that's when you split it up. But if we have time for 12 delegations and only 11 delegations apply, the caucuses will not have to review them because everybody who applied will be on the list. So we will either have room on the list for people to be added and then nobody has picked any, or we will have them picked and then each list will be full. The lists that are full would have the choices of each party on them.

M^{me} France Gélinas: I'm talking about the lists that are not full. People coming and submitting late would still be accepted.

The Chair (Mr. Ernie Hardeman): Yes, on a first-come, first-served basis, if there's more room. The one thing I think the committee needs to understand is that if they're put on the list and then more come than we have room for—there's one space open and three come—we're going to fill that on a need-to-know basis. Again, we can't send that to three caucuses to decide which one of the two are going to be picked to do that. So we'll leave it to the discretion of the Chair and the Clerk to fill the list. If there's more than the list will hold, the caucuses will decide who will be on that list. Does that suit everybody?

We need to give the researcher—I think that these are likely the same instructions that they get from everyone: background material, summaries of oral presentations; what is it that the committee wants from the researcher as we go through the process; written summaries, written submissions, interim reports, and by what date. I think, because of the fact that this isn't one of these hearings that has to be done when we get back, as far as deadlines and so forth, we likely don't need to release them until we're back. I don't see any reason to put everybody on a deadline.

Yes, France?

M^{me} France Gélinas: I wouldn't mind if the researchers could give us which LHIN are we in, a little bit as to—most of the LHINs have their top five priorities or strategic plans. If we're going into a community, it would be nice to know the name of the LHIN, maybe the name of the chair and the executive director, as well as what are the top five priorities of that LHIN. If there are any contentious issues that you pick up through the papers specific to the LHINs, let us know so we don't look like fish out of water when we get there.

Ms. Helena Jaczek: And further to that, a bit of a demographic profile. I think each LHIN is required to do that—so the population of the whole LHIN, the various distinctive characteristics of that particular LHIN, some sort of description.

M^{me} France Gélinas: With a map.

Ms. Helena Jaczek: Yes, with a map.

M^{me} France Gélinas: Some of them are pretty weird.

Mr. Mike Colle: And in the map, can we include the community health centres, the family health teams and the hospitals, anything of a structural nature that deals with health delivery?

Ms. Helena Jaczek: I think the LHIN should have that, actually, on their website. It would be useful.

The Chair (Mr. Ernie Hardeman): I expect in each place that the committee goes, the LHIN will in fact be one of the people that wants to present; that would be my guess. It would also include, as Mr. Colle suggested, a lot of those people funded by the LHIN who want to speak about it too.

I think it would be helpful to have a package for each place we're going, as to the information that's available before we hear from them, as to the geographics and the financial situation of it and how many people they serve

and so forth. It's one of these things—if this committee was going out with a bill and having these types of hearings, the ministry would prepare a binder for each committee member with the information on the people you're talking to and so forth, and we did have a little extra time between the time of the deadline and actually hearing the delegations. If we had a list of those delegations with a bit of information about each delegation as to what to expect from them and so forth, like you would see if you were doing a bill, I think it would be quite helpful.

Ms. Helena Jaczek: Chair, I'm not sure if this is the right time to raise it, but when we come back after the tour—we know that we asked for a number of associations to appear, and the Clerk is working through that; but the other question is, the LHINs from the greater Toronto area will not have had an opportunity to present during our tour. I think, for completeness, I would really like to hear from the ones in—we've heard from Toronto, but I would like to hear from Central West, Central East, Central and Mississauga Halton as well, because we're not going to catch them on our tour. I think the Clerk is looking ahead to some of that—

The Chair (Mr. Ernie Hardeman): If I might suggest, it's a very good idea to schedule them for—what should we say—the first week back, and this is the right time to do that, for the first meeting or two meetings coming back, so we can finish those off as though they were part of the traveling process, because we haven't got anything set up for the other people yet, anyway. I think to put them all in the same package—it would be a good time to hear from them right after we get back, the first meeting. We could just have the Clerk set those up.

Interjection.

The Chair (Mr. Ernie Hardeman): That's the question: Do you set them up in the same format that we had before, or do we go to the 15-minute presentations?

M^{me} France Gélinas: To me, the two-hour presentations were really for the main groups that are funded by the LHINs. I'm not interested in giving two hours to each of the LHINs. When we travel, they will have 15 minutes like everybody else. The three Toronto LHINs can have 15 minutes when they come, just like every other LHIN. The people we wanted to give more time to are the major transfer payments, so that's the hospitals, mental health, the AOH, the community care access centres—the main provider groups that are funded by the LHINs. Those are people who can tell us an awful lot about the LHINs. But the LHINs themselves, after we will have heard from 11 of them—three more, I agree, but 15 minutes like everybody else.

The Chair (Mr. Ernie Hardeman): Okay. I don't disagree, but I think that we might want to make that a half-hour so there would be time for questions. I think it would be a great idea to have all of the ones that you mentioned, France, put in the same day.

Ms. Helena Jaczek: I don't disagree with 15 minutes. I think the primary issue for the GTA is boundaries. We

will have heard a lot by then, but I really would like to zero in on that.

The Chair (Mr. Ernie Hardeman): Okay. We'll have the Clerk set up the meetings for that first date back with the greater Toronto area LHINs.

Interjection.

The Chair (Mr. Ernie Hardeman): Yes, 15 minutes, so they won't have to spend days writing a speech.

Anything else?

M^{me} France Gélinas: And the rest of them? We haven't heard from the Ontario Hospital Association. We haven't heard from the community care access associations. Those people still need to be scheduled to come.

The Chair (Mr. Ernie Hardeman): As I say, when we get back we'll have another meeting to set all those up because we'll have to plan our work plan beyond that. The only reason I think that it's appropriate to put these in is because if we don't plan it now, then when we get back, in the first meeting, all we get to do is plan who

we're going to invite to the next meeting. This will give us that next meeting and be part of this package—that same meeting, only 15 minutes. Hopefully that same afternoon we'll be able to set up how we're going to hear the rest of the people who are on the list to be heard. How many are there?

Interjection.

The Chair (Mr. Ernie Hardeman): There are 18 organizations on there—

M^{me} France Gélinas: No, she has added a whole bunch that, to me, we don't need two hours with.

The Chair (Mr. Ernie Hardeman): Okay, but right now we're just planning that one meeting and then we'll go on from there. Is everybody happy? All in favour, say "aye." The motion is passed.

That concludes that, and now that we've got it done, we'll go in camera.

The committee continued in closed session at 1632.

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Official Report of Debates (Hansard)

Monday 27 January 2014

Journal des débats (Hansard)

Lundi 27 janvier 2014

**Standing Committee on
Social Policy**

**Comité permanent de
la politique sociale**

Local Health System
Integration Act review

Étude de la Loi sur
l'intégration du système
de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 27 January 2014

Lundi 27 janvier 2014

The committee met at 0900 in the Clarion Hotel and Conference Centre, Fort Erie.

LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Good morning, ladies and gentlemen, the members of the committee. We're happy to be here in the great city of Fort Erie. The committee on social policy is looking at a review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act. We're happy to be here in Fort Erie, as I said, this morning, to have our first hearing outside of Toronto to hear what the people of the rest of Ontario think.

We'll start with the first delegation this morning. We will have 15 minutes per delegation in the committee, and the deputant can use any or all of the 15 minutes for the presentation. If they do not use all the time and there's less than four minutes left—and this is an arbitrary time—we will, in rotation of the parties, give it to one party for questions and answers. If there's more than four minutes, we'll try and divide it evenly among all three caucuses.

MR. DOMINIC VENTRESCA

The Chair (Mr. Ernie Hardeman): With that, our first presenter is Dominic Venstra? Is that—

Mr. Dominic Ventresca: Ventresca.

The Chair (Mr. Ernie Hardeman): Very good. Thank you very much. I was going to say that we would hope you would introduce yourself for the benefit of Hansard. Since your microphone was on and you have done that, we thank you very much for doing that. Welcome, and we will start the presentation. The floor is yours.

Mr. Dominic Ventresca: Thank you, Mr. Chair and members of committee. It's a pleasure to be here to share some insights with you on the very important topic of our LHINs and health care in Niagara. I'm Dominic Ventresca, as you mentioned, and I'm going to hopefully provide to you today some personal and professional insights into the effectiveness of centralized/decentralized ministry models of delivering health care and then the current LHIN model. I've had 38 years of experience, and so I'm sharing some insights. I'll provide some practical examples that demonstrate my views on the relative

effectiveness of the LHIN model in its functions of planning, funding and coordinating, and in its role of being responsive and innovative in finding better health care solutions. Then I'll provide at the end some suggested next steps and improvements.

As a little personal context, I'm coming here as a private citizen. I have a keen interest in the quality of health care in Niagara. I'm currently a volunteer in a number of local health and community service organizations. I was born and raised in Niagara, and worked for 38 years in this field, 36 of those years in Niagara.

Professionally, I graduated with a BA from the University of Toronto, as well as a graduate diploma in gerontology, from one of the first programs in gerontology in Canada, also from U of T. I'm now retired, from 2012. I was director of senior services for Niagara region, and in that capacity we ran eight long-term-care homes accommodating almost 1,000 residents. We have 10 adult day programs and a number of other community programs—supportive housing and so on—serving thousands of people and families in the Niagara region.

I was also formerly a board member of the Ontario Association of Not-For-Profit Homes and Services for Seniors, which has about 200 members, as you know, across the province and represents long-term-care homes, seniors' housing and other programs. Also, I was a member of numerous networks and collaboratives within the HNH B LHIN.

A little bit of history here, briefly: I've had occasion to work with a centralized ministry where our relations as providers were largely with officials in Toronto, and also with a decentralized ministry where area offices were formed. There are two; we worked with the local bureaucrats, but with a very strong central direction. Most recently, we've worked with LHINs as providers, and there was a shift to dealing with a local office that dealt within a provincial policy framework.

A quick comparison of models: From my experience, the centralized and decentralized—I'll couple them together—were both centrally directed and controlled, with little allowance for local input, innovation and responsiveness. With the current ministry/LHIN model—and I have a number of examples to support some of my statements here—there is a provincial framework for major policy areas. There is significant opportunity for local input, and there is an improved opportunity for innovation and responsiveness to local needs and better care.

Community engagement is one of the examples where I think the current model has advantages. For example, in developing the strategic health systems plan, a steering committee was established by the LHIN. I was a member of that steering committee and had opportunities to provide input from the gerontological and long-term-care perspective. We had a review of best practices and leading practices worldwide given to us, to guide us in our thinking. We identified a common vision for transformational change for health care. This included the need for integration and also the role of the LHIN as a health system commissioner, which was based on some practice from England. Also, there was plenty of opportunity for providers, stakeholders and citizens to provide input.

Another example around the area of provider relations with the LHIN: I cofounded and co-chaired the long-term-care homes network once the LHINs were formed, and also was a member of the community support services network. By being members of these networks, which were basically driven by the desire of providers to get together to share information and so on, we communicated among ourselves. We also communicated as a group, as a sector, to the LHIN leadership. It gave us a sense of functioning in a health care system, and it also helped break down the silos that we had traditionally functioned under. Also, it led to the formation of numerous collaboratives, which led to planning efforts and coordinating of person-centred care and requests for funding.

Another example around local program development under these three models that I mentioned before—centralized, decentralized and LHIN models—is the regional dementia care centre for Niagara. Local needs had been identified under the former Niagara District Health Council for such a centre, and various needs studies pointed to the need, but when we pitched this to the ministry area office, we were basically refused on the basis that it wasn't part of a province-wide policy and therefore was not to be funded locally. However, when the LHINs were formed, we ultimately pitched it there. It was supported, and now it's funded and it's integrated, in fact, into the provincial Behavioural Supports Ontario framework as a best practice, or at least a leading practice replicated in other LHINs.

Another example of local program development is in the area of long-term-care-home residents. The LHIN board made some bold decisions a couple of times to redirect an annual surplus of long-term-care-home nursing funds, which normally would be returned to the province, to keep them locally and to meet resident needs based on good needs addressed by local providers. So we were consulted, as a long-term-care-homes network, and we were funded for installing Ontario Telemedicine Network, or OTN, technology in the long-term-care homes across the LHIN, and also for leadership education for RNs and RPNs, front-line health care leaders, to provide better care to residents.

Another example is around Behavioural Supports Ontario. This is where we formed a collaborative locally.

It was formed to enable provider input into the local implementation of this provincial program. We had agreement among providers to pool resources. We recognized a management committee that was struck to oversee, and we also recognized lead agencies that came forth among our group to implement this BSO program across our LHIN. Coordinated dementia care was being provided in long-term-care homes and in the community across the LHIN by this effort of collaboration and co-operation.

Another example is around assisted-living hubs in Niagara. This was a cross-sector collaborative; again, people who would not have normally come together, but we formed this collaborative. We applied jointly for LHIN funding and we got seniors' social housing, so the housing sector came together with those of us in providing community services, and we turned several social housing buildings into assisted-living complexes by introducing 24/7 personal support workers. Accessible bathing suites were adapted in the buildings, and also wellness programs are provided on-site. Then, the success was allowed to extend into the community, where we provided the same services to citizens living on their own in their own homes in local neighbourhoods.

Another example is around the Niagara Health and Wellness Centre, where another cross-sector collaborative formed to jointly apply for LHIN funding, with in-kind support from Niagara College. They offered building space and student placements and supervisions for some of the students who will deal with, largely, seniors in their careers later. It also served an underserved area of south Niagara. We offered at one site, at Niagara College, an enhanced adult day program, falls prevention, a stroke clinic, rehabilitation and geriatric assessments, which were accessed now in a community setting. They were previously either not accessible or accessed outside of south Niagara.

Briefly, a few suggested next steps: Generally, I think that the committee should consider enabling further evolution of local health care planning, funding and coordination. I think it should allow stabilization of health care improvements and continue tracking system performance indicators to monitor progress. I think you should enable the next set of system improvements and proposed investments, as identified in the five-year LHIN Strategic Health System Plan, in order for it to achieve results.

More specifically, I think consideration should be given to holding the gains already made in health care system transformation, provider collaboration, operational efficiencies, and better care, such as—and there's data to show this—improved patient flow and the whole alternate-level-of care issue, reduced wait times, community and mental health care coordination, and clinical program integration among hospitals and in the community.

Secondly, for more awareness and engagement, there should be a focus on improving the community's and the media's understanding of the relevance of the LHINs in improving local health care and services; strengthening the involvement of local providers/stakeholders/citizens

in improving local health care and in deliberations with the LHIN board; and increasing public transparency and availability of relevant documents and reports.

Thirdly, for improved communication, I believe there should be a focus on strengthening communications and building better relations with local municipal elected officials and leaders; increasing plain-language public reporting of key LHIN initiatives in various accessible media; and ensuring information sharing and replicating best practices among the 14 LHINs.

Mr. Chair, that concludes the statements that I wanted to make. I'd be happy to engage in any conversation with you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have—I set the arbitrary mark at four minutes and we have exactly four minutes, so we will give it to the official opposition. Ms. Elliott?

0910

Mrs. Christine Elliott: Thank you very much, Mr. Ventresca, for your thoughtful presentation. You raised a number of items. I wish I could ask about more but I'll just concentrate on some of the last issues that you mentioned under "Suggested next steps": Strengthening the involvement of local providers and stakeholders in improving local health care. Could you elaborate a little bit more about what you mean by that?

Mr. Dominic Ventresca: Yes. I think there's always room for improvement. If there is a greater understanding of the relevance of the LHIN and a greater feeling of transparency and accessibility from the public, I believe that more individuals or more groups in the community would feel comfortable about making delegations to the board or submitting information that they really feel will have an impact on health care in their community.

Mrs. Christine Elliott: And has transparency, in your view, been lacking of late in this LHIN?

Mr. Dominic Ventresca: I think it's a matter not so much of lacking; there's always room for improvement. I worked in the municipal sector for 36 years, and all the rules around regional council and so on were built largely around openness, transparency and availability of information. I think there are lessons that can be learned from other public domains that can be transferred to the LHIN, hospital boards and other major, important entities within our society.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated, and we look forward to hearing many more so we can make—I'm sure with your help we'll make educated decisions on improving the system. Thank you very much for your presentation.

Mr. Dominic Ventresca: Thank you for the opportunity.

UNIFOR LOCAL 199

The Chair (Mr. Ernie Hardeman): Our next presenter is Wayne Gates, the president of Unifor Local 199.

Wayne, if you would come forward. Welcome this morning, Mr. Gates. We appreciate the time you're taking to come in and talk to the committee. I don't know if you were present before the other one started, but you will have 15 minutes to make your presentation. You can use any or all of your time for that presentation. If you do not use all your time and leave four minutes or less, the questions will go to the third party. If you leave more than four minutes, we will divide it evenly among the parties to ask questions and make comments. With that, the floor is yours. I don't want to use up any more of your time than I need to.

Mr. Wayne Gates: You're suggesting I talk a lot, is kind of where we're at? Okay, I'll try.

First of all, my name is Wayne Gates. I am president of Unifor Local 199 in the Niagara region. I'm a lifelong resident of Niagara. I'm also the NDP candidate for the upcoming by-election in this riding. I thank the Standing Committee on Social Policy for coming to Fort Erie. I thank you for the opportunity to speak of this long-overdue review of the Ontario Local Health Integration Network and to speak about the local LHIN here in our community, the Hamilton Niagara Haldimand Brant LHIN.

When the Liberal government passed a law to create the LHINs, they promised a review like this in four years. That was back in 2006. I have to point out that this is now 2014, eight years later. This review should have happened four years ago. If this review had happened when it was supposed to, four years of problems could have been avoided.

Under this government's watch the people of Niagara have had more than their fair share of problems with the local LHIN. Putting off this review has caused damage. It has denied our community the chance to speak—open and transparent—and to express our concerns. Our hope is that this review will lead to real change, but for so many in Niagara, hope has faded.

People here know me and my record on health care of standing up for all. I have always fought to keep access open to the best-quality health care for people when they need it and where they need it, no matter where they live in our communities.

When the Liberals closed down the ER in Fort Erie, I stood with the yellow shirts. For those who might not know, that was a group that was put together to save their hospital. They had a rally here in Fort Erie with 5,000 residents who attended.

When the Liberals cut services in Niagara Falls, I stood with expectant mothers—and this is one that I've never understood, and I've said this before. Niagara Falls is the honeymoon capital of the world. It's actually where a lot of people from around the world go to make babies. Yet in Niagara Falls, we can't even deliver them. I've never understood the thinking behind that.

When the C. diff outbreak was raging through our hospital, I stood with patients' families where people died. It has been an uphill battle to get the government to listen to the needs of the people of our region. I can tell

you, in Niagara Falls, I organized a rally because we didn't know that C. diff was in our hospitals; we didn't know that people died from C. diff.

I had a rally there, and the rally was called *You Have the Right to Know*. You have the right to know, when a senior goes into that hospital, that there are issues in that hospital. You have the right to know that if you're having your loved one—and this is what happened right across Niagara: They went in for knee surgery, and they went in for hip surgery, and they caught C. diff and they died. But before they went to that hospital, they never knew.

We didn't feel we were getting the attention, and as more and more people died in Niagara, I organized a victims' rally. Why did I do that? Because we wanted to get the message out that nobody should go into our hospitals in Niagara for knee surgery or hip surgery and come out dead. I listened to the victims, who told their story on how that dreaded, dreaded disease ate away at them. From that rally, it went across Ontario. It was on the local radios, but more importantly, it was on CHCH. More importantly, it was covered by CBC right across the country. I believe because of that, and because of the emotion that was around losing a loved one, that heightened the awareness of the C. diff crisis that we were going through here in Niagara.

It's no surprise that our local LHIN has let us down, because the LHIN is an agency of the government. Many in our community feel that the LHIN has not met our health care needs. Instead, it seems that the main job of the LHIN is to shut out our views. Planning and coordinating health care services is very important work, but for health care to move forward, the public needs to be included and consulted, not overlooked, not ignored. Unfortunately, that's what has been happening in Niagara for too many years.

Unelected LHINs hold great power and responsibility in our health care system. The government made the LHINs responsible for planning, coordinating, funding health services in hospitals, community care centres, community support service organizations, mental health and addiction agencies, community health centres and long-term-care homes. Quite frankly, the Liberal government has shifted responsibility for most of our local health care to the LHINs and, unfortunately, the blame as well.

0920

This LHIN is made up of six members, government-appointed, on an unelected board that has not been accountable to the people of Niagara. Even some local journalists have been blocked when they ask for information about the LHIN. If professional journalists are kept in the dark about the LHINs and what they are doing, then how can people in Niagara know what's happening with their health care? When the LHIN refuses to share information with the public, that means it's not accountable. When the LHIN refuses to inform us—and I give you an example—about their decisions until weeks after they've been made, then that means it's not transparent. When LHINs shut out the public and make decisions

behind closed doors, that means we have a serious problem.

The Ombudsman of Ontario agrees. In 2010, after getting complaints about the Hamilton Niagara Haldimand Brant LHIN, André Marin investigated. He found that our local LHIN wasn't involving the community in important decisions about health care in Niagara. It wasn't open; it wasn't transparent. Worse yet—I think this is important—he found that the board members had passed an illegal bylaw that let them meet behind closed doors for so-called educational purposes. He found that these secret meetings were then used to discuss restructuring plans with the key players—again, important—away from public view. No public meetings, no public dialogue. It took a report from the Ombudsman to finally get the Ministry of Health and Long-Term Care to act. It took the Ombudsman to make the local LHIN involve our aboriginal and francophone communities.

But a recent article in the *St. Catharines Standard* shows that the culture of secrecy hasn't gone away. In November 2013, the newspaper asked for immediate access to the board's monthly meeting reports rather than waiting six weeks after. First, the LHIN said yes; then the LHIN said no. Then they changed their mind again and said yes to public access right before the review—right before this. It's not coincidental; it's damage control and it's political. Health care shouldn't be about politics. Health care should be about Canadians, Ontarians, to make sure that when we go to the hospital, we're going there to get better. We're not going to the hospital for vacations. We're going to the hospital because we're sick, and we should be going there to get better.

LHINs make decisions that directly affect the health and well-being of our seniors, our children, our parents, our grandparents and ourselves in our community. But this LHIN is leaving us in the dark. The Liberal government invented the LHINs, and then they paid their friends top dollars to run it: hundreds of thousands of dollars for executives, almost \$1 million on consultants in one year alone from 2010-11.

As you were paying out these dollars, the millions, what was happening here in Niagara? We were having cuts to our services, closing our hospitals; \$1 million more on administration costs. All this money, and we hear we can't afford to provide health care in our communities. It could have gone to health care, our front-line workers. They're doing an incredible job every day they go to work, being asked to do more and more.

It's time for the Liberal government to own up to the actions of their LHINs instead of using them as political cover for unpopular decisions, like contracting out cleaning services—which I believe was a major issue here in Niagara—and closing hospitals and ERs in our communities. Even the Ombudsman says that the Ministry of Health and Long-Term Care uses the LHIN as a way of ducking responsibility.

I don't blame the public for feeling disappointed. I don't blame my neighbours for feeling angry. The people of Niagara had to wait too long for this review to come here: eight long years.

This review should have happened four years ago. We should have had our say on how health care decisions are made for all of us. We all deserve to be treated with respect, and our concerns should be considered. Citizens have the right to know.

If this LHIN isn't doing the job it's supposed to, if it makes secret decisions in closed-door meetings, if it continues to shut out the public from important health care decisions, if it refuses to be transparent, if it refuses to be accountable, then the Hamilton Niagara Haldimand Brant LHIN should be abolished.

I'd like to thank the Chair. I'd like to thank the committee for giving me a few minutes of your time today to make my presentation. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. You did do a great job of using your full 15 minutes. Thank you very much for your presentation, and I'm sure it will be quite helpful to the committee.

Mr. Wayne Gates: I really appreciate you giving me the time to be here today.

MR. WILLIAM MILLAR

The Chair (Mr. Ernie Hardeman): Our next delegation is William T. Millar. Is Mr. Millar present? Thank you very much, sir, for coming in this morning. We very much appreciate you taking the time, in particular as I see in some parts of the area the weather is not quite as good as it might be this morning.

As with the other delegations, you will have 15 minutes to make your presentation, and if you have time left over at the end, if it's less than four minutes, it will go to the third party. If it's more than four minutes, then it will be divided equally among the three caucuses for questions or comments. I haven't told the others this: If you use all your time, when we get to two minutes, I'll put my two fingers up so you'll know that you're getting near the end of your time.

With that, thank you very much. The floor is yours.

Mr. William Millar: Thank you, Mr. Chair. I want to thank the LHSIA review committee for this opportunity to participate in the review process. I served as a member of the board of directors of the Hamilton Niagara Haldimand Brant LHIN from March 2007 to March 2012.

My professional background is in public education as a teacher, consultant, principal and a senior administrator. I served as director of education of the Niagara South Board of Education from 1990 to 1998 and as associate director of the amalgamated District School Board of Niagara to retirement in 1999. Following that, I worked with the Education Quality and Accountability Office on a quality indicators program for elementary and secondary schools.

I must say that I'm heartened by the fact that a review of LHSIA is being undertaken. Public education—I regret that we did not often examine the results of the many changes that were made in our system, leading to confusion and disenchantment often among education practitioners, students, parents and the general public, and

undoubtedly to uncorrected mistakes. Such reviews require the examination of both hard and soft information and data. I hope that the LHSIA review process will take advantage of the broad range of information that is available from a variety of sources.

0930

The perspective I bring to the review process reflects experiences, learnings and observations during the early period of the LHIN's work, some volunteer involvement with the development of the LHIN's current strategic plan after my board term, and interest as a member of the community since that time.

I believe the LHSIA/LHIN concept of providing for local involvement and authority in planning, integrating and funding health care is a sound one. There may well be differing opinions on what "local" means, and challenges in dealing with the variety of communities with different circumstances, needs and priorities, but there can be little doubt of the difficulty of trying to deal with a highly complex system, such as health care, only from the standpoint of a central authority.

The local LHIN provides, through its board, a group of citizens who bring a variety of perspectives, experiences and skills to the tasks of planning and integration. During my terms, I worked with board members who championed rural health care issues, the needs of the marginalized in urban areas, the health issues of area aboriginals, mental health needs, the challenges of providing for the ever-growing seniors population and so on. They had no illusions about the scarcity of resources and the need to be good stewards of the public purse. While their insights from the communities in which they lived, and the various providers with which they were familiar, were shared, they maintained a system perspective and commitment.

This is a singular strength of the LHIN model. A LHIN board can maintain a system perspective while drawing on the strength, commitment and special knowledge of the volunteer board, provider boards and their members.

It was evident from early on in my board service that the first appointed members of the HNHB LHIN board, particularly the chair and vice-chair, were able to recruit an outstanding first CEO, and that she in turn had assembled an excellent staff. They were and are highly dedicated to their work in establishing both an effective LHIN and a quality integrated local health care system. While I carry some bias towards the HNHB LHIN, I had the opportunity to meet and work with LHIN CEOs and staff from other areas, and I think the province can be satisfied that it is being extremely well served.

From the outset, LHIN CEOs and their staffs recognized the importance and necessity of working with and learning—even perhaps friendly stealing—from their counterparts in other LHINs. As you know, there are formal and regular meetings of all the LHIN CEOs and chairs. In addition, there has been significant collaboration among the LHINs on everything from the development of common forms and procedures to joint development of programs. All of the LHINs regularly contribute staff to province-wide projects.

In addition to the obvious benefits of consistency of practice in common areas and the sharing of scarce resources, cross-LHIN collaboration has created a whole new resource for Ontario's health care system. Collectively, LHIN staff represent a level of expertise in health care planning, funding and integration, that is grounded in the experience and understanding of local systems and providers, that I do not believe existed prior to the development of the LHINs.

Indeed, it is hard to imagine how large-scale programs such as Aging at Home, addressing the alternate-level-of-care issue, and the various wait-time reduction projects initiated by the Ministry of Health and Long-Term Care, with often-challenging timelines, could have ever been successfully implemented without the skill and commitment of LHIN staff. In addition, the relationships which they have developed with the local provider organizations ensured that such programs were effectively designed and implemented at the local level.

It is clear to me that the funding and accountability authority provided to the LHINs under LHSIA has been important in enabling the integration and quality agendas to move forward. I believe that changes being considered in the LHIN mandate will further strengthen their work. But in the HNHB LHIN and, I'm sure, others, more emphasis has been placed on establishing rapport, credibility, trust and a shared commitment to a quality, integrated health care system with the provider organizations and their members than on the exercise of authority.

As a board member, I was impressed with the willingness of busy physicians and other health care professionals to take leadership roles in a variety of projects to address quality and integration in their respective fields. That involvement has led to great work in addressing the challenges of wait times, chronic disease management and many others.

In particular, the HNHB LHIN has developed and partially implemented a clinical services plan that serves to ensure commonality of practice and patient experience across the LHIN. That plan has coordinated such clinical services as complex continuing care, vascular and thoracic medicine, cardiac care and cancer care to date, and implementation in all clinical services is continuing. The clinical services plan ensures that best practices prevail, no matter the location of the treatment. Success in these endeavours requires the ongoing trust and commitment of all of the partners in the health care enterprise.

The collaborative approach taken at the local level has also gone a long way in helping the smaller organizations in the health care system to deal with such new realities as service plans, accountability agreements, and quality measurement plans and processes. While organizations such as hospitals had considerable experience in these areas, they represent challenges to the smaller providers with more limited human resources. I had the pleasure as a board member to observe the patient, helpful manner applied by the LHIN staff not only at submission time but throughout the year, albeit with the clear understanding that the task could not be shirked.

The LHSIA review provides an opportunity for the Legislature, the Ministry of Health and Long-Term Care and the LHINs to examine what has been accomplished to date and where things need to go. The challenge of providing quality, integrated and affordable health care to a populace whose needs seem ever-growing and of managing the complexity of the system that seems to be needed to meet those challenges can be overwhelming. I believe that the emphasis now being placed on the individual patient or client and his or her experience, while a simple concept, is a powerful one. It provides both the rationale and the direction for integration. It focuses measures of quality and identifies improvement directions. It provides the best map for organization of services and hopefully ensures that all levels and components of care are planned and funded in terms of their contribution to the effectiveness of the individual's experience.

Clearly, the inclusion of primary care in the LHIN mandate is a key to the complete and effective integration of health care services and the resulting quality and effectiveness of the patient/client experience. I am aware that consideration is being given to this direction. I would suggest that the success that the HNHB LHIN has had in establishing a positive working relationship with primary care physicians can lead the way in resolving this issue and ensuring that this important and necessary component of patient care and system navigation formally becomes part of the pursuit of a fully integrated health care system.

While I believe I've made it clear that the big stick of funding does not work on its own, LHIN control of funding does create opportunities to incent certain directions being taken that are important to system goals. It is hoped that the LHINs' funding authority and their ability to exercise local flexibility continues to be strengthened as the LHIN concept matures and further gains the confidence of all those involved.

Earlier in remarks I made, I referenced the important role the LHIN boards play in bringing varied perspectives, experiences and skills to planning, policy and decision-making. As well, their system perspective serves as an offset to their provider board counterparts' narrower focus at the governance level. Board members are also a key component of community engagement activities. It is thus important that processes for board member succession be such that a full board complement is maintained as much as possible and that departing members are replaced thoughtfully and in a timely fashion. I would respectfully suggest that the board appointment processes be examined with a view to these goals.

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I have not addressed in any specific way actual measured outcomes that I believe need to be examined as part of the review and assessment of the LHSIA/LHIN model. I'm aware of significant improvements in such areas as surgical and diagnostic imaging waiting times, alternate-level-of-care statistics, and admission to long-term care

versus alternatives. I'm equally aware that emergency wait times seem to resist improvement efforts, at least locally, and that mental health and addiction resource difficulties may be contributing to that. It also seems clear that the necessary shift of resources from sectors such as hospitals to the provision of home care, for example, is a difficult one, especially in challenging economic times. But I have neither the currency nor the expertise to properly relate these indicators to the changes in approach that the LHINs have brought. Such an analysis should be done by those with that expertise, and the learnings from that analysis applied to the health care transformation efforts.

As I've indicated in my earlier remarks, I believe that the integration of health care services is bearing fruit in the system's effectiveness and efficiency, and that the LHIN approach to that integration has the best chance of success.

I thank you once again for the opportunity to present to you and to be part of this important review process. I really believe that the province of Ontario got it right in this first move to providing local health authorities. I know you're aware of the models in other jurisdictions, both in Canada and beyond. Most of these jurisdictions continue to examine and often change their structures, and so should we.

I believe, however, that we are well served by a structure which has maintained the strength of skilled, thoughtful volunteers at the provider board level, has left operational management to those who know it best, and has recruited system governance that is committed to an effective and sustainable health care system that is ultimately measured by the quality and effectiveness of the individual's experience of it.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about a minute and a half. If the third party would ask the questions.

Ms. Cindy Forster: All right. I'm going to ask a question, actually, that I'm sure Donna would like me to ask. I know that it happens in LHINs across the province and in Niagara as well.

First, I thank you for being here today and for your thoughtful presentation.

Services even within LHINs are not consistently provided to patients. You can have four municipalities bordering on each other, for example, and clients and patients in Hamilton are provided with different services than are available, say, to clients in Niagara. In your experience on the board—and I hear about that in my constituency office on a regular basis. Somebody from Niagara, for example, goes to Hamilton for surgery, but when they come back to Niagara, they actually end up getting different services than the same patient in Hamilton might have been provided with, post-discharge from the hospital, let's say. Can you give us some insight into how the LHIN is trying to address that within LHINs as well as across LHINs?

Mr. William Millar: Well, I can refer to my time. As you know, it's about two years now since I was on the

board. I believe that's where the work I mentioned earlier about collaboration among the health service providers—the clinical services plan and the integration of care that that has brought—has created a really broad sharing across the LHIN. Continuing that process will go a long way to address the kinds of variations that you've referred to.

As you may know—I'm not sure how strong the knowledge is—the current strategic plan of the LHIN divides the LHIN up into somewhat larger areas, and its sole purpose is to coordinate the health care services within those and, in so doing, to create a greater commonality of availability in quality and access in each of those areas. So the work is continuing there.

Obviously, the starting points were different in many of these cases, and the resources may not have been available to bring them on at the same pace, but I think that local planning, especially through the strategic planning, through the LHIN concept, is the best chance of addressing it.

The Chair (Mr. Ernie Hardeman): Thank you very much for your time and thank you very much for being here this morning and for your informative presentation.

Mr. William Millar: Thank you.

COUNCIL OF CANADIANS, SOUTH NIAGARA CHAPTER

The Chair (Mr. Ernie Hardeman): Our next presenter is the Council of Canadians, South Niagara Chapter, Fiona McMurran. Thank you very much for coming in and sharing your presentation with us this morning. As with the previous presentations, you will have 15 minutes allotted for your presentation. If there's less than four minutes left at the end of your presentation, it will go to the government caucus. If it's more than that, we will split it evenly between the three caucuses. With that, thank you very much again for coming in. If you get to within two minutes of the time allotted, I will put up my fingers to let you know you have two more minutes. Thank you very much for coming in, and the floor is yours.

Ms. Fiona McMurran: Thank you very much, indeed. I do appreciate being able to present to you all. My name is Fiona McMurran, and I am a 30-year resident of Welland. I'm here representing the South Niagara Chapter of the Council of Canadians. Among its campaigns, the Council of Canadians also works for the preservation of Canada's public health system and the strengthening and enhancement of the Canada Health Act.

With other organizations, we have been drawing public attention to the expiry this year of the Canada health accord. As you know, the Prime Minister has refused even to meet with Canada's first ministers to renegotiate the accord, preferring instead to announce substantial cuts over a period of years to the health transfers to the provinces and territories, all of which are fighting ballooning health costs.

Austerity budgeting arrived in Ontario in the midst of a radical restructuring of the province's complex and

unwieldy health care system through the creation in 2006 of 14 local health integration networks. You have been hearing about the progress of the LHINs with this re-organization. It is our contention that the province's health system is moving rapidly in a direction that will further erode medicare and that the LHINs, while doing much difficult and very demanding work to integrate health services in Ontario, are also serving inadvertently to mask the significance of some of these changes from the public while also preventing the Ministry of Health from having to actually face the consequences of its own policy decisions. We shall never have the public dialogue on the future of health care in Ontario that we so desperately need under the LHIN system.

As creations of the province, reporting to the Ministry of Health, the LHINs carry out policy directives from the ministry, dispensing funding to various health providers, including hospitals. They are a buffer between the public and the providers and the ministry. The act that created the LHINs includes a duty to consult; although the wording is open to interpretation, the intention is clear.

Here in Niagara, unfortunately, we feel that the LHIN system has failed us twice: once in the case of the Niagara Health System's Hospital Improvement Plan, hastily introduced without consultation in mid-2008, and now again, in 2014. As you know, health care restructuring began with hospitals. In fact, consolidation of hospital services has been ongoing since the days of the Rae government, the wisdom of the time declaring that bigger was always better and more efficient.

We have already been subject to dramatic restructuring of our hospital system, with the downgrading of three small hospitals within the Niagara Health System to urgent care centres. Only last week, the province endorsed the closure of the other hospitals in Welland and Niagara Falls, along with the closure of those urgent care centres. Yes, we have been promised a new hospital and two new urgent care centres, but, especially in the current financial climate, why should we trust these promises? We've heard promises before.

The release of the Niagara Health System's Hospital Improvement Plan in the summer of 2008 came like a bolt out of the blue to most of us. Indeed, the mayors of both Port Colborne and Fort Erie had been recently advised by the NHS president and CEO that their small hospitals were not under threat. But the HIP, as we call it, called for both of these to be downgraded to urgent care centres, as well as for the closure of the majority of departments in both the Welland general and the Greater Niagara General Hospital in Niagara Falls. None of this, we were assured, had any connection to the decision to build a new hospital in St. Catharines to replace that city's two aging institutions.

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This dramatic consolidation of hospital services, we felt, had been decided behind closed doors, without consultation with doctors in the health system, let alone the community.

Appeals to the NHS, the LHIN and the Ministry of Health fell on deaf ears, so a number of individuals

brought their concerns to the Ontario Ombudsman. As you are well aware, André Marin's office investigated the allegation that the HNHB LHIN had failed to adequately consult the population prior to approving the HIP. His findings were published in August 2010 as *The LHIN Spin*, in which he roundly castigated the LHIN for failure to consult.

What followed was exactly nothing. The HIP continued to roll out, and those of us who were afraid that the next target for closure would be the mid-size hospitals in Welland and Niagara Falls appealed to the Niagara regional council for support, which finally came in early 2011, when a delegation of regional councillors were at last able to persuade the health minister to strike a tripartite committee to review the HIP. That committee had barely begun its work when the health minister put the NHS under supervision.

Kevin Smith was named as supervisor, and the NHS board was dismissed. Smith's first public appearance in Niagara was as a guest at the tripartite committee meeting in early September 2011. He explained his mandate as supervisor and disbanded the tripartite committee, which was now unnecessary since Smith would, of course, be reviewing the HIP as part of his duty to get the NHS back on track.

Smith was a logical choice from the ministry's point of view, having been brought in as supervisor when other Ontario hospitals ran into trouble.

From our point of view, it was somewhat worrying that Smith was CEO of a hospital, St. Joseph's Healthcare, just up the road, as it were, in Hamilton—a hospital also included under the Hamilton Niagara Haldimand Brant LHIN. Was this not a case of conflict of interest?

Since September 2011, when Smith took over as supervisor and the board was dismissed, there has been virtually no hard information forthcoming from the NHS. What was the status of the NHS deficit? How was the new hospital in St. Catharines proceeding? How was staffing coming along?

Smith himself acknowledged, late in 2012, that the new hospital had not succeeded in recruiting the mental health specialists it needed, and that Niagara patients would be dependent to some degree on services at his own St. Joseph's. I also understand that the new hospital is utilizing specialists from Hamilton health services in its cardiac catheterization lab.

As you are well aware, Smith produced his final report on the NHS for the ministry in September 2012. In that report, he recommended the closure of all remaining NHS sites, including the Welland general and the Greater Niagara General Hospital.

Since these have been the property of the hospital system since amalgamation in 2000, Smith intends that they be sold. To replace these services, he advocates a new hospital for what he terms "south Niagara," an area that, for the first time, includes Niagara Falls, the largest urban centre here outside of St. Catharines, and the building of two stand-alone urgent care centres.

The financial case for this is somewhat thin on detail, to say the very least. Smith compares the cost of reno-

vating the two larger hospitals, Welland and Niagara Falls, with the cost of a new hospital in south Niagara, and—surprise—comes up with a smaller figure for the latter alternative.

Not only was there nothing to support those figures, there was no attempt to define the services that the new hospital would provide, or explain where the two new urgent care centres fit into the financial projection, or to indicate that the hospital, at least, would be a P3 project and therefore double the amount at the end of 30 years.

Local mayors, unfortunately, were less interested in close scrutiny of Smith's report than in playing a game he had set up called "decide amongst you on a site for a new hospital," a game that has set municipalities in the south against each other in the same way that the HIP has set north and south Niagara at odds. Predictably, since Smith has indicated from the beginning that a renovation of the Niagara Falls hospital wasn't worth the cost and had shown little to no interest in Welland, the Niagara Falls site has won out.

In October 2013, St. Catharines city council was finally successful in its request to hear from the NHS. Acting president and CEO Dr. Sue Matthews spoke briefly and to the point, telling us that the NHS is in fact in dire financial straits, such that it lacked the resources to open the 100 beds at its new facility in St. Catharines. In order for this new hospital to fulfill its mandate, Matthews declared, the NHS would require a funding increase of 3% to 4% on its annual budget. The present government has declared that there will be a 0% increase in hospital budgets.

This startling news generated no response from Supervisor Smith. The new hospital board, although appointed in May, was yet to call its first meeting. Sue Matthews resigned her acting position in December to take up a position as hospital CEO in Australia, and we were getting what seemed to be conflicting signals from the health minister, who roundly praised Kevin Smith and his proposals, and the Premier, who stated firmly that she could not commit to a major public infrastructure project like a new hospital until she had made progress in eliminating the province's deficit.

With the sudden resignation of Kim Craitor last fall, the Smith plan, with its proposed new hospital for Niagara Falls, became a hot-button issue, especially when endorsed by the Progressive Conservative leader. As the date approached for dropping the writ for two bye-elections, Kathleen Wynne could no longer put off a decision on Smith's proposals. Not only were his recommendations approved, but a \$26.2-million planning grant was announced to permit further development of the south Niagara hospital proposal.

How can the ministry justify spending \$26.2 million on consultants to develop a plan for another new hospital when it can't afford to run the one that has just opened? And where, I ask, is our LHIN in this decision?

For many of us in south Niagara, the significant part of this announcement lies not in the promised new facilities but in the official government approval of the

closure of the old ones: the UCCs in Port Colborne, Fort Erie and Niagara-on-the-Lake, and the Welland and Niagara Falls hospitals. The important question there is: When? Can the NHS, unable to make its new hospital fully operational, afford to retain hospital services in Welland and Niagara Falls until a new hospital opens, or will it move swiftly to enact these closures to save on staff and administrative costs, and put these sites on the market? If so, where will the services go?

Some, we fear, will be outsourced by the LHIN. As you heard before the Christmas break, the ministry is poised to make an amendment to the LHIN act, enabling the LHINs to fund independent health facilities, or IHFs. Procedures not requiring hospital stays will be shifted to clinics in the community, funded by OHIP through the agency of the LHINs. Under a community-based specialty clinic initiative of the Ministry of Health, low-risk hospital services will be moved from hospitals to community clinics, which, though private, will, we are assured, be non-profit—for now. For us, this constitutes a significant step away from the public delivery of health services.

Did the LHIN call for public input into this? No, because it was a ministerial decision. One does have to wonder whether, when low-risk hospital services move to such IHFs, they are likely to be reabsorbed later into a new hospital. It seems unlikely. It appears much more likely that our old hospitals will close, the services will be outsourced, and, well, we'll see whether there's actually a case to be made down the line for another expensive hospital in south Niagara.

Or perhaps we're cynics as well as dinosaurs. We're constantly told down here in the south of Niagara that we stand in the way of progress, that small hospitals are a thing of the past and have to go, and that anyone standing up for them has his or her head screwed on backwards—unless the small hospital in question is further up the QEW, nearer to the big health care hub of Hamilton.

Residents of Lincoln county were understandably devastated when plans to replace the aging West Lincoln Memorial Hospital were shelved in the 2012 budget. But last year, West Lincoln and Hamilton health services amalgamated, with the blessing of the ministry and our LHIN. At its meeting this Wednesday, our LHIN board will endorse the proposal to revive the planned replacement of the West Lincoln Memorial Hospital. It seems that the rebuild was a key negotiating factor. The LHIN says, "The future redevelopment of the WLMH site was an important consideration in garnering support for the amalgamation."

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These are not LHIN decisions, I realize; these are ministry decisions, but from these decisions, all others flow. Yet it seems to us that the major players in the hospitals are poised to take over control of other services. In our corner of Ontario, Kevin Smith has announced the end of his supervision of the NHS and has been appointed as CEO by a board that has yet to meet. He will continue as CEO of St. Joseph's Healthcare, a network of health care

institutions that includes long-term-care homes. Although he states he does not foresee an amalgamation of the NHS with St. Joseph's, he is clearly anticipating some sort of further consolidation between the two, one that will also involve Hamilton health services, creating some form of sub-LHIN.

The moral of this story is this: Hospital consolidation looks like a money-saver, but it's also an empire-builder, especially if the power over non-hospital health services is going to reside within those hospital systems.

The entire face of health care is changing entirely, and we cannot afford to vest such power in the hands of a few mandarins from the Ontario Hospital Association. For my part, I see the LHIN system as merely obscuring the scope of these changes and getting in the way of meaningful discussion in the media and in the community about how we preserve any kind of human scale, any sense of community, in the delivery of health care in Ontario. When we see—

The Chair (Mr. Ernie Hardeman): Thank you. Your time has expired. Obviously, you have presented a copy of your presentation to the committee.

Ms. Fiona McMurran: Yes, I have.

The Chair (Mr. Ernie Hardeman): The committee will read that part which you were unable to get into the 15 minutes.

We very much appreciate your presentation. Thank you.

Ms. Fiona McMurran: Thank you so much.

FOYER RICHELIEU WELLAND

The Chair (Mr. Ernie Hardeman): Our next presentation is Foyer Richelieu Welland, Sean Keays, director general. This next presentation will be in French, so we have the translation on the desk, and we will start the machine.

Thank you very much for coming in. We very much appreciate it and we look forward to your presentation.

Mr. Sean Keays: Well, I—

The Chair (Mr. Ernie Hardeman): If I could, as I mentioned previously, you will have 15 minutes to make your presentation. Any time left, if it's less than four minutes, will go to the government caucus. If it's more than four minutes, it would be divided to the three caucuses together.

Mr. Sean Keays: I just wanted to thank you for the opportunity to do my presentation in French. It means a lot to our organization. I'm the CEO of the only French long-term-care home in southern Ontario, called Foyer Richelieu, and I see some good friends.

So if you don't mind, I'll just start in French. If there are any questions and you prefer to ask them in English, I don't mind.

Il y a plusieurs points que j'aimerais toucher aujourd'hui pour votre considération. Comme vous voyez, je vais vous donner des solutions possibles, des prochaines étapes.

D'abord, la première considération est de—

The Chair (Mr. Ernie Hardeman): Excuse me, we don't have any sound.

Ms. Helena Jaczek: Press the one.

The Chair (Mr. Ernie Hardeman): One? Okay.

M. Sean Keays: And please feel free—if you need me to repeat something in English, I'd be happy to do it.

Ma première recommandation ou considération principale est de laisser faire n'importe quelle idée qui a affaire avec l'élimination des RLIS, c'est-à-dire les « LHIN ». Ce qu'on devrait faire, c'est regarder à leur donner plus de pouvoir. Ce qui est important pour nous autres, c'est si on éliminait des RLIS et on les donnait au ministère à Toronto, ça veut dire qu'on créerait d'autres jobs quand même. Nous autres, ce qu'on aime, c'est quand on fait affaire avec des gens locaux qui connaissent notre communauté, connaissent nos besoins et nous connaissent comme des « service providers », si je peux le dire. Comme j'ai dit, c'est le temps de leur donner plus de pouvoir.

Puis, une des considérations que j'aimerais vous donner, c'est d'amalgamer les centres d'accès avec les RLIS, c'est-à-dire les « CCAC » et les « LHIN ». Puis, ce qu'on pourrait faire ici, c'est de créer des sites pilotes où peut-être vous trouveriez deux ou trois leaders dans la province qui pourraient entreprendre ce défi. D'abord, je sais que la directrice générale du Toronto Central a déjà géré, comme directrice générale, un centre d'accès, et maintenant elle est directrice générale d'un RLIS. C'est la même chose avec notre directrice générale ici à Hamilton-Niagara où elle a les capacités, une très bonne équipe et un site « beta », c'est-à-dire un site pilote. Ceci, comme vous pouvez l'imaginer, réduirait les coûts d'administration—moins de bureaucratie, et en même temps, moins de conseils d'administration.

L'autre est d'éliminer la duplication des services dans les RLIS. Par exemple, je sais que dans l'endroit de Sault Ste. Marie, il y a environ cent organismes qui représentent les services de soins mentaux ou de dépendances, c'est-à-dire « addictions ». Là, amalgamer ces services-là, avec peut-être un ou deux directeurs généraux ou directrices générales, puis éliminer plusieurs conseils d'administration—ça sauverait des gros dollars. Puis, j'imaginerais que ces exemples-là pourraient être reflétés à travers la province.

Celui-ci est proche à mon cœur parce que je suis directeur général d'un foyer de soins de longue durée. This one's close to my heart because, obviously, I manage a nursing home for francophones. On a plusieurs lits disponibles. Ici à Niagara, en 2008, 96 lits de soins de longue durée ont été promis. Puis, ce qui est arrivé c'est qu'ils ont tous été mis de côté. On aurait pu construire ces lits-là plusieurs années passées. D'abord, ce qu'on pourrait faire c'est de donner plus de pouvoir aux RLIS. Avec ce pouvoir-là, ils ont la capacité de dédier ces licences. Quand il y a des lits « in abeyance », si je peux dire, qu'est-ce qu'on pourrait faire? Mon foyer, on a deux places libres dans le sud de Niagara. Vous avez déjà entendu que c'est là où il y a une urgence à cause d'un manque de lits.

Ce qu'on pourrait faire c'est de donner aux RLIS le pouvoir de redistribuer ces licences-là sur une base intérimaire, jusqu'au temps que ces lits-là sont construits. Puis, ce qui peut arriver s'ils diront dans notre RLIS : « On n'a plus de places à les dédier. Il n'y a plus de "service providers" qui ont de la place pour »—ce qu'on pourrait faire c'est de trouver, avec le ministère des Soins de longue durée, des RLIS où il y a un manque de lits de soins de longue durée et, encore une fois, de dédier ces lits-là sur une base intérimaire.

C'est de l'argent qui a été déjà « budgeté » à travers le gouvernement, mais ce sont des lits qui sont, comme j'ai dit, « in abeyance ». C'est un bon mot anglais.

Mon dernier point est de considérer « l'accountabilité » avec les entités de planification. D'abord, c'est un projet sur lequel la ministre Deb Matthews et la ministre Madeleine Meilleur ont travaillé très fort plusieurs années passées. On a des entités de planification à travers la province. Avec ça, je pense que ce serait intéressant s'il y avait des réunions régulières entre les deux directrices générales, c'est-à-dire « CEO on CEO ». Je comprends que les « CEO » des RLIS sont du monde très occupé, mais s'ils ne peuvent pas se rencontrer de temps en temps, il serait important qu'ils dédient quelqu'un de haut niveau comme un vice-président ou quelqu'un avec du pouvoir décisionnel. Moi, ce que j'aimerais voir, et je pense que ça va un peu dans la mission de la ministre Meilleur et de la ministre Matthews, où on pourrait avoir un pouvoir égal où ils se rencontrent avec un consensus et des buts atteignables pour trouver comment on pourrait améliorer les services pour les francophones dans notre RLIS.

Ça, c'est ma présentation. Je voulais vous donner cinq bons points. Si vous avez des questions, ça me ferait plaisir—if you have any questions, I'd be happy to answer them in French or in English.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about nine minutes left, so we will divide it equally: three minutes for each caucus, with the government caucus first.

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M^{me} Helena Jaczek: Merci, monsieur Keays. Je vous demande pardon, mais c'est plus facile pour moi de vous questionner en anglais—

M. Sean Keays: Il n'y a rien là, mais vous parlez très bien en français.

Ms. Helena Jaczek: Merci. We've heard a diversity of views this morning, as I'm sure you're aware. Overall, I would hear from you that you are firmly in the camp of supporting local decision-making within a geographic area such as the LHINs provide. Is that sort of an overall theme?

Mr. Sean Keays: Yes, absolutely. A couple of things I mentioned: It's great that we have these local leaders that we get to know, who know us and know our communities.

At the same time, the one thing I was cautioning is that if there was an elimination of the LHINs, they would have to create these jobs in Toronto anyway, and then we

would lose that personal touch. You wouldn't be saving any dollars. What I'm saying is, if there's any buzz going around, just completely dismiss and eliminate those kinds of talks—and give them more power.

Ms. Helena Jaczek: I think, given the history across Canada of regionalization of health care, every province has come to the conclusion that local input is really important. So as long as we're in government, you can rest assured that we will continue.

But of course, what we're here to do is to improve, or potentially make some suggestions. You've made one suggestion related to the amalgamation of the CCAC and the LHIN. By that, I'm assuming you mean that you would disband the board of the CCAC.

Mr. Sean Keays: That's right.

Ms. Helena Jaczek: And it would simply be a direct service provider of the LHIN. Is that how—

Mr. Sean Keays: That's exactly right, and to evaluate, to look at maybe a couple of beta sites, a couple of places where you could pilot. I mentioned two names here. In Toronto Central LHIN—I put her name there—she was CEO of the CCAC and the LHIN. I know that our team here within the Hamilton Niagara are very capable of doing it, and it would be a good example of a beta site where they would have more power in regard to the CEO and her team here or in Toronto, or wherever it is decided, where they could manage both the LHIN and the CCAC together.

Ms. Helena Jaczek: Yes. Now, we heard earlier today a suggestion about primary care becoming, perhaps, part of the responsibilities of the LHIN. Do you have any view on that?

Mr. Sean Keays: Yes, absolutely; that's basically the crux of my presentation. I'm not sure how much we want to throw at the LHINs at one point. But I think that a good strategic plan over time is to evaluate which ones would be more priority and then to see what we could do to give them more responsibility, like the primary care. I think that that's a great point too.

Ms. Helena Jaczek: So you see the trend in that direction—

Mr. Sean Keays: Absolutely.

Ms. Helena Jaczek:—expansion.

The Chair (Mr. Ernie Hardeman): Okay, thank you very much. To the official opposition: Ms. McKenna.

Mrs. Jane McKenna: Thank you so much for coming in here today. I had a bit of a hard time—I don't know if anybody else did—hearing it in English. Nevertheless, you say that the LHINs are very effective and efficient, and yet when I read your recommendations here, it kind of puts me in a bit of a panic that there's a lot of waste going on here.

My first question is, if you say "elimination of duplication of services within the LHINs," does that not worry you that there's a lot of money that's being wasted, if there's so much duplication going on that you have through your whole presentation?

Mr. Sean Keays: You've made a good point. I appreciate you bringing that up. In regard to what I was saying,

I think that the LHINs are very efficient. I think they're doing very well.

I've been back in Ontario for four years, and I think it's about 10 years or so, give or take a couple of years, that the LHINs have been in place. I think there's a lot more that they can do. For the first decade, we've been doing very well, and I think that there are other things where there is duplication. This is the areas—a few that I've mentioned, and our colleague here mentioned primary care—that would be definitely things to see if we could create beta or example sites and then, from there, continue to improve, because there's always room to improve. I think that that's what the purpose of this meeting here today is.

Mrs. Jane McKenna: Yes, there are a lot of improvements that you're recommending here.

For seven years, they have been measuring their performance and trying to be effective and efficient. Do you think that's a long time, seven years, to try to iron things out?

Mr. Sean Keays: I know that most businesses—when I look at our little place, we usually do a strategic plan for about five years. Right now, I think they've had one or two, and it's time to move it along and get some of these services amalgamated or see how we could improve. I think we've done well, but we could do better.

Mrs. Jane McKenna: Okay. Now, my next thing was, I was kind of wondering why this isn't happening now. Your very last “next step” is “Emphasis that all LHIN CEOs meet regularly” with you and that the CEOs “achieve goals determined upon consensus.” Is that not happening now?

Mr. Sean Keays: I know some LHINs are doing very well there and I know others can do better. So I think it would take a responsibility where LHINs, the CEOs, their board—they just had a meeting a couple of weeks ago, I think, for what they call the tripartite committee; I don't sit on this organization, but it's something that's close to us because they do help service providers that are francophone. And, absolutely, I think this is something that was introduced a couple of years ago, maybe two and a half years ago, and I think we have to go to the next level where there's a consensus on decision-making.

There need to be responsible goals too. We can't just say, “Let's build a French hospital in Niagara.” That would be maybe a long-term goal, but to at least have short- and medium-term goals and try to attain—I think that some LHINs are doing very well at it and then others are not doing as well. I'm happy to say that our LHIN here is doing very well at it.

Mrs. Jane McKenna: One thing—

The Chair (Mr. Ernie Hardeman): Thank you very much. The third party: Ms. Forster?

Ms. Cindy Forster: Thanks, Sean, for being here today. Maybe you can expand a little more on the relocation of the long-term-care licences.

For the committee's information, in 2008, Welland was awarded beds by the government: 96 new beds. It's now 2014 and those beds still haven't been built. So it is

problematic in Niagara. We do have a wait-list, which I'm sure Sean can update us on. The problem seems to be that these licences just sit out there in an abyss, where they could have actually been reallocated to other agencies within Niagara.

Mr. Sean Keays: Thank you, Cindy. Yes, I appreciate you bringing that up again. For us, it's so important because in our home we have two open beds that are ready to go. All it would take is a little bit of paint, and we have staffing. It would almost be a sunk cost to us.

When I look at south Niagara—there are probably other regions throughout Ontario that have been going through similar challenges where there's a shortage of beds and they've been identified as an emergency area, where when you think of Ontario, there are about 77 long-term-care beds and there are maybe about 20,000 to 23,000 people waiting. In Welland, there are approximately 400, and there are 400 people. So it's a big gap in regard to the waiting time. We get calls every day—if it's not me, my assistant—“How can we get in quicker? What can we do to get on the list?” When I see that there are these 96 beds—it's great that they've been awarded and there are plans for them to be built, but in waiting, these are dollars that have already been budgeted. We should look at finding out where there are homes that have availability on an interim basis, if it's a one-year. They already have that LHINs give out so many interim licences, the ministry, where they've noticed there are places in emergency—but to maximize on these dollars that have already been promised and to give the LHINs those powers, because they know if it's within the LHIN. After they've been through every home and there's no more place for these interim licences, then maybe see if there are places outside the LHIN, and maybe that would be a joint effort with the Ministry of Health and both LHINs, and then they could designate those licences on an interim basis.

The Chair (Mr. Ernie Hardeman): Thank you very much, and thank you very much, sir, for your presentation this morning.

Mr. Sean Keays: Thank you.

MS. PAT SCHOLFIELD

The Chair (Mr. Ernie Hardeman): Our next presenter is Pat Scholfield.

Ms. Pat Scholfield: Good morning.

The Chair (Mr. Ernie Hardeman): Thank you very much for coming in this morning and being with us, sharing your thoughts. As with previous presenters, we've allocated 15 minutes for your presentation. You can use any or all of it for your presentation. If there's time left over, if it's less than four minutes, the government side gets that. If it's more than four minutes, we'll divide it evenly among the three caucuses for questions. So with that, the floor is yours.

Ms. Pat Scholfield: Thank you. My name is Pat Scholfield and my topic is a grassroots view of LHINs.

What is a LHIN? I would venture to say that 95% of the people of my community of Port Colborne have no

idea what a LHIN is or what they do. I would be in that 95% had it not been for a couple of letters to the editor in our local paper around 2006. The letters stated that a new hospital was going to be built in St. Catharines and it was probably eventually going to be the only major acute in-patient hospital in the region of Niagara, and they were planning on building it in the wrong location. It should be more central to the region. I decided to jump in and write supporting letters, as it was clear to me the far northwest corner of Niagara was not the geographic centre of the region.

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While I loved my Port Colborne hospital and had received nothing but the best of care there through the years, I understood the benefits of consolidation of specialties, such as critical mass, equitable access, best practice and all those pet phrases that are thrown around willy-nilly. But if you are going to consolidate major acute specialties into one hospital, it is critical that the hospital is located to provide everyone equitable access. This was definitely not the plan in Niagara. It was time to battle to get a common sense solution to this problem.

I then discovered our hospital no longer belonged to the people who paid for it, but was an asset of the Niagara Health System, the NHS, which had been amalgamated in 2000, operated all the hospitals in Niagara and had their head office in St. Catharines. I tried to talk to them but got nowhere.

Around 2007, the NHS made various moves to close departments at Port Colborne hospital, and riled up some of our local people. To keep them quiet, the NHS CEO, Debbie Sevenpifer, sent a letter to the city of Port Colborne in December 2007 that the NHS was fully committed to our full-service hospital and a vital 24/7 ER. The Ministry of Health and Long-Term Care further backed this up by approving a \$400,000 renovation of the emergency department at Port Colborne.

You can imagine our surprise when, in July 2008, the NHS dropped a bombshell on us by announcing they were releasing the Hospital Improvement Plan, also referred to as the HIP, which proposed converting the 24/7 ER to a 14-hour prompt care centre, and closing the operating room and all acute in-patient medical beds at Port Colborne hospital. That is when I discovered the LHIN. They were the body that had ordered the NHS to prepare the HIP, as the NHS had been running serious deficits since their inception.

The LHIN's job was to fund, oversee and integrate our hospitals and make sure hospitals did not run deficits. From 2000 to 2007, the NHS had run up a long-term debt of \$160 million, and in 2007, an annual deficit of over \$18 million. The LHIN ordered the NHS to prepare the HIP to get their budget balanced by 2013.

Are LHINs local? Our LHIN was called the Hamilton Niagara Haldimand Brant Local Health Integration Network. They claimed they were our local voice. I decided to attend some of their meetings. It took me between an hour and an hour and 15 minutes to reach their headquarters in Grimsby. It didn't seem very local to me.

Are LHINs open and transparent, and believers in public consultation? They will tell you they are, but I believe it is all window dressing and a sham.

Apparently, our LHIN had the final say as to whether to approve the HIP. At one session, the LHIN board members asked some pointed questions. At the next meeting, the LHIN staff had answers that would encourage the board members to endorse the HIP, which they did. It was a jerry-rigged deal, or, as a local mayor said, it was a predetermined decision.

A number of us were incensed with the system which led to the approval of the HIP, and contacted the Ombudsman with our complaints. The Ombudsman then did an investigation into the HNHB LHIN and eventually released his report: The LHIN Spin. The report showed the LHIN public consultation process was severely flawed and at times illegal.

Has this changed anything? Not really. They act like they want to hear from the public, but in reality, their minds are made up. The following is an example:

The LHIN included me in an ACTION committee in the fall of 2012. We were supposed to discuss innovative ways to improve the health system. I believe we were fed questions to guide us to supply answers that would fall in line with the LHIN's predetermined direction. For instance, they tried to convince us health care should be taken out of the hospitals and into the community. I sent through an email, basically expressing my thoughts, that in many cases the hospital is the heart of the community, and that rather than have private clinics set up which would require rent to be paid, it would be better to locate these services in the hospital, where many of them were fully paid for, with no mortgages, and pay the rent to the hospital system, thereby generating revenue.

I also made the point that rather than have private clinics distributed all over the community, it would be better to have them housed at one location: the hospital, where there would be one-stop shopping.

The LHIN CEO put my comments on her blog, but the ACTION report did not reflect any of my suggestions but continued the predetermined mantra to move services out of the hospital and into the community, as though that was what we all agreed on.

Now, you are allowed to attend LHIN board meetings once a month but do not have access to many reports. Several times I would ask for a report to no avail. Finally, in April 2011, I sent an email to LHIN CEO Donna Cripps, asking for a specific report, which had been received and filed. She said she would get back to me.

In May, I had not received anything and emailed her again, and got the following response from CEO Cripps: "Our governance working group of our board of directors is working on a protocol to determine how best to share information with public who are at the board meeting both during the meeting and following the meeting.... I will not lose your request and I will respond as soon as I have direction." To date, I have not received this report.

Are LHINs temporary or permanent? When the LHINs were first set up in 2006, they were supposed to

be reviewed in five years. That never happened, and now it is eight years. The first HNHB LHIN meeting I attended in 2008 was held at the town hall in Grimsby, as the LHIN's offices were in leased rooms in a small mall. A few years later, they constructed their own building across the street. It looks permanent to me.

Now we are told urgent care centres at our hospital must be taken out of our hospital and placed in free-standing, leased facilities, and yet the LHIN has their own nice, new digs. Explain that.

Should we take politics out of health care decisions? Definitely. If we had, the only new acute in-patient hospital to be built in Niagara in 50 years, and probably the last for the next 50 years, would have been built in the geographic centre of Niagara, but a prominent Liberal cabinet member lives in St. Catharines.

Mistakes were made, which the LHIN approved, that were not based on best practices. The LHINs were appointed by a Liberal government. Over \$1 billion should not have been committed to a project without absolute assurance by the LHIN that this was the best possible medical decision for all the citizens of Niagara. This was their mandate. Had the right decision been made, everyone in Niagara would have been within one half hour from a full-service acute in-patient hospital.

The HIP was approved by the LHIN and implementation began. Within a couple of years, the hospitals in Niagara were plagued with a serious C. difficile problem and enormous public anger and mistrust brought about by the drastic cuts of the HIP. Health Minister Deb Matthews sent Kevin Smith as supervisor of the NHS to supposedly restore trust, but I believe the main goal was to divert the public's attention while the remainder of the HIP was put fully in place, with obstetrics and pediatrics consolidated into the new St. Catharines hospital.

He created the diversion by proposing another new hospital for south Niagara, but it is in the north and Liberal riding of Niagara Falls, and many people feel it is because of the by-election to be held there next month. Is this another political decision? I personally believe, once the election is over, that enhanced efforts will transpire to consolidate the remaining acute in-patient services to St. Catharines, and we will never see another new hospital anywhere in Niagara.

Now, this should be a serious issue for our LHIN, as the residents of south Niagara will not have reasonable access to emergency hospital services, which may result in untimely deaths and poor patient outcome.

Interestingly, the main point of the HIP was to address the serious \$18-million annual deficit, and with Smith overseeing the NHS, the annual deficit by October 2013 was \$12 million. It was supposed to be balanced by this date.

Where do we go from here with the LHINs? I wish I had a solution. Obviously, LHINs have made certain they are firmly entrenched and are busy building a permanent empire. As it stands now, it seems to me that the Ministry of Health sets policy, funnels it down to the LHINs and they, in turn, funnel it to the various health systems under

their umbrella. They are a very expensive middleman. I personally am concerned they are an unnecessary level of bureaucracy that is constantly writing reports and creating plans ad nauseam to justify their existence. It is not likely there will be anything we can do to remove them.

Bearing this in mind, I would recommend they be held to a very strict budget and do some severe pruning, as they do with the hospitals, and a local person from each municipality be appointed to the board who is elected by the municipality, with the responsibility that they must appear at council on a regular basis, once a month or quarterly, to inform the public as to the LHIN's direction in layman's terms.

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The biggest challenge will be to keep politics out of health care decisions and to include the phrase "common sense."

I put in a little addendum here. Since the preparation of this report, I discovered, because of an investigative report, that our LHIN would not release requested reports. The LHIN has now decided they will make board meeting packages available to the public a few days prior to board meetings. They should, in my opinion, not only share information, but webcast their meetings and invite citizen participation during open-mike sessions, as they do at the Erie St. Clair LHIN.

I should also mention that I went on the site on Friday and noticed the board meeting package, but I noted that there were reports in there—there was a big, long memorandum of understanding between the LHINs and the ministry and another template of multiple sector use. But there were some reports that had been received and filed, and there was no report there. I'd like to see some of those reports that are received and filed.

Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about three minutes. With that, the government side: Mr. Colle.

Mr. Mike Colle: Yes, I'm just trying to figure out the difference between what the last speaker said and what you said. You're basically saying you'd like to see things centralized back in Toronto for decision-making; you don't want to see any regional or local say in health matters—because if you get rid of the LHINs, who's going to decide and give input to the Ministry of Health?

Ms. Pat Scholfield: I'll leave that up to you expert people, but I don't believe the LHINs—in my opinion, from a grassroots view, I haven't seen huge improvements. I realize there's a need for consolidation, but there was no common sense used in that here. We were like guinea pigs here. They decided they were going to put this big new hospital up in the far northwest corner of the region, and then everything was going to be sucked up there and they're going to do it gradually. The public was not informed.

The public doesn't know what LHINs are. Everybody I talk to, they have no idea what LHINs are. So they've done a very poor job at explaining to the public what

they're all about. If they want to give them an opportunity for input, come to some of the council meetings and have them come and ask questions. Explain what they're doing.

As far as the centralization, I won't profess myself to be really knowledgeable on that, but I have read reports where they said they've tried these ideas, like LHINs, in other provinces and have found out they didn't work. They've gone back to centralization. If you have a good local voice that speaks to the centralized power, maybe that might be the answer; I don't know. But that's what you're here for.

Mr. Mike Colle: Anyway, I agree with you that many people don't know what a LHIN is, unless they're involved in health care delivery, like yourself. You went to the extra effort of getting involved, which is really what is good about what you did.

Ms. Pat Scholfield: Yes. But it costs money to travel there, too.

Mr. Mike Colle: No, I know; it's not easy. That's why I think we're here today: to get those kinds of recommendations for you. I lived through the centralization thing. I had three of my local hospitals close in the middle of the night—emergencies closed—in the old centralized model. We didn't even know it was going to happen; they were gone. I think people have said, "We need something to have some kind of local say," so that's how they came up with the LHINs. They're far from perfect—

Ms. Pat Scholfield: But they're not local.

Mr. Mike Colle: I'm saying, then, if you don't have them, what do you have? You're back to Queen's Park making all the decisions behind—we've got the biggest health ministry in North America. How can a person in Wainfleet ever have anything to say on what's happening at Queen's Park in that huge—so they're trying to bridge the gap, I guess. That's why I think your recommendations of how to make them more local, how to make them more, let's say, accountable, are good ones. We're here to listen to those proposals, like you've made, and I think they're very good ones because there is a gap between the public and the LHINs—I agree with you—and I think there should be a lot more transparency and connection, as you've just demonstrated.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It was very well done.

Ms. Pat Scholfield: Thank you.

RETIRED TEACHERS OF ONTARIO, DISTRICT 14 NIAGARA

The Chair (Mr. Ernie Hardeman): Our next—uh-oh; it seems I've lost my agenda here. McMaster University, Niagara Regional Campus: I believe they're not here yet.

Is the next one here, the Retired Teachers of Ontario, District 14 Niagara, Bill Doyle, chair? If he's here, we'll carry right on by the last one. Hopefully they'll arrive to take your spot. Thank you very much for coming in.

Mr. Bill Doyle: Thank you very much.

The Chair (Mr. Ernie Hardeman): As with the previous delegations, you'll have 15 minutes to make your presentation. You can use any or all of that time. If you don't use it all and leave less than four minutes, the questions will go to the official opposition. If you leave more than four minutes, it will be divided equally among the three parties, starting with the official opposition. So thank you very much again for coming in and the floor is yours.

Mr. Bill Doyle: I guess I'll have to speak fast.

The Retired Teachers of Ontario represents over 3,000 members in the Niagara Peninsula. Our district is one of 46 districts in Ontario with a total membership of approximately 70,000.

Since the inception of the Hamilton Niagara Haldimand Brant LHIN, RTO/ERO District 14 Niagara has had representation in attendance at most board meetings. Because of our familiarity with the public workings of the LHIN, we feel we must use this opportunity to address the following points, as we note how they affect the Niagara Peninsula sector, which includes Grimsby, St. Catharines, Fort Erie and Port Colborne: decision-making, ongoing conversation among residents, accountability, access, quality and sustainability.

Decision-making: We appreciate the creation of LHINs to plan and decision-make for health care closer to home rather than having decisions made outside the community. In theory, the creation of a home base LHIN is positive. It empowers people within the community to make decisions for the community in which they live rather than have one unfamiliar with the environs decide on our behalf. Unfortunately, local decisions do not always have a positive effect on the whole community. In its own documentation, the HNHB LHIN acknowledges that it covers a sizeable area. The complexity of the HNHB LHIN is not advantageous to the successful implementation of decisions that would improve health care in Niagara. Since the HNHB LHIN serves a large area with many disparities, our presentation focuses solely on health care for seniors in the Niagara Peninsula.

The HNHB LHIN recognizes that there is a large and growing senior population within its boundary. A study would show that the majority of seniors currently within the LHIN live in the Niagara Peninsula. In addition, seniors moving to the area will choose the peninsula rather than the Hamilton area. The presence of these new seniors places an immediate additional strain on required services within the peninsula. The expectation is that even more services will be required as the senior population increases disproportionately to the rest of the province. Therefore, we would expect that the funding would increase to match the unique needs of the area.

Possible solutions could include funding following seniors moving to Niagara; expanding the satellite program that trains doctors in our area; implementing a mandatory geriatric component in training for all health care personnel; increasing geriatric services; increasing services through the partnership with Hamilton Health Sciences; and, changing the focus from NHS deficit

problems to a focus on patients in desperate need of quality care.

Ongoing conversation between the LHIN and residents: According to the vision for local planning and decision-making, there is to be ongoing engagement and conversation among residents. There is no ongoing engagement or conversations at board meetings in our LHIN. Although our RTO/ERO regular representatives provide both a name and contact information when we sign in for the meetings, we have never been invited to share our feedback about any issues. Usually our regular members are the only interested parties in attendance and we do appreciate the opportunity to learn what is happening in health care. We share the information with our members in Niagara.

We recommend that the government oversee all LHINs throughout the province in a way similar to the method in place in Erie St. Clair. That would mean that all LHINs in Ontario would:

- provide opportunities for engagement and conversation within the community;

- provide presentations and/or materials prior to meeting to aid understanding of issues to be discussed. Curiously, our LHIN has just announced that it would intend to change their practice of keeping such information secret and begin sharing it publicly. I checked the Internet, and it's on there now;

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- provide the opportunity for those present to seek clarification; and

- encourage ongoing rapport through communication between LHIN members and those who provide contact information.

To provide information on what is happening regarding health concerns in our community, we hold workshops. We have invited members of the HNHB LHIN, local CCAC and other providers to carry out these workshops for our members. We would appreciate an opportunity to give input back to the HNHB LHIN.

Accountability for public expenditures and health outcomes: Although there may be improved accountability for bookkeeping for the purposes of balancing budgets, our concern is more specific to patient outcomes. We are concerned about what happens when clients do not get the services they are supposed to be provided. We recommend that the LHIN have a body where concerns can be expressed and that the LHIN act as an advocate on behalf of patients.

Access: It has been our experience that there is a discrepancy in wait times for cataract surgery. Some patients, in order to receive timely service, have had to go outside our LHIN. For elderly patients, transportation is a serious impediment to access.

The CCAC health care workers are constantly being changed for a variety of reasons. Because of differentiated staffing, one client may have to see several workers for assistance in the home. There have been incidents where two clients in the same home are being assisted by two different persons at the same time. We suggest that im-

provements be made so that more attention is paid to the grouping of patients within geographical areas; that, as more patients are managed in their homes or long-term-care facilities, more funding is needed for CCAC; and more training of PSWs, and that that training be expanded to include more areas of care.

Quality: Hospital-borne bacteria are of great concern to patients and their families. Although prevention policies have been developed, the LHIN should review those policies and make improvements where necessary based on best practices, and have the mandate to enforce that these procedures are being followed.

Sustainability: RTO/ERO has a long-standing position on P3 hospitals and privatization of services. We believe in universal, comprehensive, portable, accessible care, administered and managed publicly. We believe in a health care system that operates for the benefit of all citizens of Ontario. Privatization and P3 hospitals are not congruent with these principles.

At the present time, according to the Canadian Institute for Health Information, Ontario has the highest share of private health care expenditures in Canada: 32.3% of total health expenditures. Private providers need to make a profit. That takes money away from the services that are direly needed by our citizens.

To allow the removal of services from hospitals into private clinics would dismantle our community hospital system. Cutting specialized services such as thoracic surgery, vascular surgery, cardiac care, birthing and maternal care, mental health services, cataract surgery and hip and knee replacements from local hospitals and centralizing them into fewer regional centres forces patients to travel greater distances for care. In addition, to transfer day surgeries, diagnostics and other services out of public hospitals into private clinics would further destabilize our public community hospitals and our access to service while increasing the cost to the taxpayer in order to provide revenue for the private providers.

P3 hospitals cost more in the long run because of higher interest rates and fees paid to the management company. These hospitals do not open with the full range of services that were promised. For example, in St. Catharines, the new hospital, which was supposed to replace the St. Catharines General, became, for all intents and purposes, a regional hospital. Although it is supposed to have 410 beds, it only opened with 325. Some departments are operating at a minimal level. There is a \$15-million shortfall in the Niagara Health System budget due to higher costs. This has an impact on staffing levels and the delivery of services at all hospitals in the region. The same holds true for the P3 hospitals in Brampton and Sault Ste. Marie.

In short, to close hospital services and expand private clinics is not supported by the evidence. There is a significant body of academic research showing poor quality, safety concerns, higher user fees, cream-skimming of the most profitable and easiest cases at the expense of local hospitals, higher costs and a host of other problems associated with the fragmenting of community hospital services into private clinics.

In conclusion, we continue to monitor the LHIN on behalf of our members, as we hope it will help improve the health care for seniors in the Niagara district. We appreciate this opportunity to express our views, and hope that improvements can be made, as we encourage our members to live healthy lifestyles. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have five minutes left, so with that, we'll start with the official opposition, and we'll each have about a minute and a half.

Mrs. Christine Elliott: Thank you very much, Mr. Doyle, for appearing before the committee today. We appreciate your comments and suggestions. I just wanted to go back to the ongoing conversation between the LHIN and the residents, and the workshops that you have. You've mentioned that you've invited people to come and speak to you. Have you found the LHIN personnel to be helpful in coming to your meetings? What's the situation at present?

Mr. Bill Doyle: Yes and no.

Mrs. Christine Elliott: Okay.

Mr. Bill Doyle: I guess I could be a politician.

The idea here is that, yes, the information has been provided. I would say that the present structure of the HNHB LHIN might be more—how would I say it?—open than with the previous person in charge. We found that it was a one-person show in the previous administration; let's put it that way.

But since then, when we do go to LHIN meetings, we're cordially welcomed—things along that line; no problem. But because we go there unknowing as to what's happening and everything else, I personally will take down maybe eight or 10 pages of notes, hopefully to try to figure out what I'm saying when I write up my report for our meetings.

But the fact that the LHIN has opened up to have the documents on the computer and accessible for people willing to go to the LHIN—I find that that's positive.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Forster?

Ms. Cindy Forster: Thanks, Mr. Doyle, for being here. Is it your impression that the LHIN has only become more transparent because we're in the process of doing this review?

Mr. Bill Doyle: I would say that it would possibly be the result of the work done by a reporter with the St. Catharines Standard.

Ms. Cindy Forster: Okay. You talked about the issue of cataracts in Niagara. Certainly, that's an issue that I hear about in my constituency office on a regular basis, particularly with respect to one physician who happens to have privileges at a hospital in Cobourg as well as in the Niagara Health System.

I've had some discussions with the LHIN with respect to that, and have been told that there probably are 500 cataracts being done per year, at least in the last fiscal year, outside of Niagara, and that is over and above the

numbers that were actually allocated within the budget. What is your sense, in talking to seniors here in Niagara?

Mr. Bill Doyle: It was amazing that you mentioned Cobourg, because that was one of the sites.

With regard to going outside, Burlington, even though it's part of the LHIN, is outside of the Niagara Peninsula, and this is where I feel that the LHIN is concentrating most of its business with regard to the Hamilton area and, hopefully, it spreads out of Hamilton.

Now, Cobourg and Burlington are the sites. They can have cataract surgery, I've heard, immediately or within up to a week. Follow-up appointments can be made locally at the doctor's office.

The Chair (Mr. Ernie Hardeman): Okay. To the government side: Mr. Colle?

Mr. Mike Colle: Thank you for your presentation. I guess that in the time given, you can't cover everything. But it seems that, finally, we're starting to understand that good health care isn't just about hospitals, that it's not just about hospital beds. It's about community health centres, medical health teams that come in place and also the home care, to keep people at home as much as possible and getting that care at home.

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So what about on that side? Are you seeing the complaints about the CCACs and the amount of care they're getting at home? Is that still mounting from what you are hearing from your members?

Mr. Bill Doyle: I can give you two or three scenarios. One scenario is that, well, on my street, for example, we had two people with heart problems and two different providers going at almost the same time. Now, this is, I would say, due to the privatization of services rather than having the public nursing system that used to be in place, because I guess what happens is as the patient's name comes up, then—you know, next on the list—you're assigned to it, with regard to the privatization. If it were one body instead of piecemeal, that would not be.

Another thing that we did find, and this was with regard to a member: CCAC assigned the provider for service. In this particular case, the provider was supposed to go daily but did not show up for a period of time. The wife complained, or when she tried to complain, she would break down in tears. So she asked a neighbour to call. The neighbour called and basically was told, "You have no business calling."

Mr. Mike Colle: The CCAC?

The Chair (Mr. Ernie Hardeman): Okay, okay. The time's up. Thank you—

Mr. Bill Doyle: Can't I get the story?

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It wasn't for the presenter; I noticed that my colleague was going to get into another question.

Mr. Bill Doyle: Oh. No, Mike is not that type.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

MCMASTER UNIVERSITY,
NIAGARA REGIONAL CAMPUS

The Chair (Mr. Ernie Hardeman): Our previous delegation has arrived, so we will revert back to McMaster University, Niagara regional campus: Karl Stobbe, regional assistant dean. Welcome this morning. Thank you very much for coming in. As with all the delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If you leave less than four minutes, it will go to the official opposition for the questions. If it's more than four, we will divide the time equally between the three caucuses. With that, thank you again for coming in. The floor is yours.

Dr. Karl Stobbe: Thank you, Mr. Chair, members of the committee and the audience. I'd like to speak from the first-hand experience that I've had engaging with our LHIN, and, first of all, to explain who I am.

I'm a family doctor. I've been in Niagara for 29 years. I practised family medicine in Beamsville and at the West Lincoln Memorial Hospital in Grimsby for over 20 years. Besides working in my office, I looked after patients in hospital, in the emergency room. I delivered babies. I looked after my patients when they were in nursing homes, and I occasionally did house calls.

Since then, I've worked at Quest Community Health Centre, caring for some of St. Catharines's more marginalized people. During my time, I started working at McMaster to create its first rural training program for family medicine residents, and since then I've spent my time with McMaster working to further develop medical education outside Hamilton, in the last six years as regional assistant dean of the Niagara campus of the school of medicine. I just want to tell you a little bit about that so that you can understand where I'm coming from.

The Niagara regional campus has been in operation since 2008. To date, we've graduated 62 doctors and currently have 84 students in our three-year program and 24 residents in family medicine, general surgery and emergency medicine, all based in Niagara. In addition to that, over 200 residents from McMaster and other medical schools have come to Niagara for part of their training. This has had a significant impact on the physician supply and people's access to care.

McMaster's vision: Within a culture of innovation, courage and collaboration, we lead by challenging what is and embracing what could be. McMaster is committed to the community. Therefore, we will adapt to changes in the local health care system. We value interdisciplinary collaboration and we've developed close working relationships with Brock University and Niagara College. Together with our partners, we have worked to promote quality of care through education. Students from Brock and McMaster work together with hospital staff on many quality improvement projects. In addition, we are able to teach interprofessional collaboration through the creation of an innovative interprofessional education unit in the hospital.

To have a high-quality education program, it is important to have a well-functioning health care system. To that end, McMaster has a vested interest in Niagara to promote the quality of care and to ensure there are enough doctors, not only to look after the population but to have additional time available to teach our students.

I've had other interactions with the LHIN. I've served on the board of directors of the CCAC, the community care access centre, one of the agencies funded by our LHIN. I have served on two occasions on planning groups organized by the LHIN to plan the future state of the health care system in our part of the province. In addition, I've served a term as president of the Society of Rural Physicians of Canada, and in that capacity met with most of our nation's health ministers, asking for policies to ensure that rural people across Canada have fair access to health care. As a result, I have some understanding of the health care systems and of the LHINs.

If I recall times before LHINs existed, I have felt some frustration, and I'm not alone, feeling that the Ministry of Health in Toronto was not very aware of regional issues in places like Niagara; it was hard to get their attention. Toronto was very far and the perception was that all the resources were concentrated in the city.

As currently constituted, I've seen both positive and negative sides to the LHINs. I'll talk a bit about both. On the positive side, for planning the future of health care, the LHIN has a more local view, has consulted widely, I believe, and has invited numerous experts, leaders and front-line health care workers from Niagara to provide input into the direction the LHIN-wide system should develop. The final directions, in my opinion, were an accurate reflection of the actual discussions that took place. It did not appear to be an engineered solution.

The LHIN has participated in planning some positive health care developments in Niagara. Their work promoting health links I think has been helpful, and the inter-professional education unit at the St. Catharines hospital was done with the full participation of the LHIN.

Bringing health care planning to a more local level seems like a good idea. I believe there is need for improvement. In my opinion, one of the major functions of government is to fairly allocate resources. Without government intervention, the rich could buy the health care they want and the poor would suffer from not having access. We know of a nearby country where this is the case. I believe that LHINs should be held accountable for fair and equitable distribution of health care funds. If this is part of the LHINs' current mandate, it could be more transparent. Clear explanations in the reallocation of health care dollars would be welcome.

Health care inequity is emerging as a major cause of ill health and shortened life expectancy. This is as true in Canada as in every other country. Even with our universal health care system, people with higher incomes have better access to care and better health. Only government can allocate resources so that people in need are served. This must become one of the major functions of the LHINs, and any assessment of their performance should include this metric.

I believe the LHINs have demonstrated potential and some success in bringing health care planning and organization to a local level. Increasing the focus on equity, both within and between LHINs, and improving transparency will increase their effectiveness and acceptance.

I want to thank you for the opportunity to speak. I could say more, but I think I wanted to provide some focus. I want to also thank the local community for continuing to welcome McMaster—we're new on the health care scene; they've been welcoming our students to particularly Brock University and Niagara College, the Niagara Health System and West Lincoln Memorial Hospital. They've all worked with us to promote an exciting educational environment for young doctors-to-be and encourage them to remain in the community after they finish. I am excited about our work together, advancing health care in Niagara.

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The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. I want to say that half of my family graduated from Brock.

The questions will be split all three—we have about eight minutes left, so we'll start with the third party. Ms. Forster.

Ms. Cindy Forster: Thanks for being here today. There have been a couple of presenters before you—I don't know if you were here for all of the presentations—but the question came up about primary care: Should primary care fall under the mandate of the LHIN? I want you to speak to that in relation, perhaps, to your comment as well around the fair and equal distribution of health care dollars within and across LHINs.

Dr. Karl Stobbe: Right. I think people need the care that's required depending on their illness. The direction of health care is shifting very significantly from the hospital into the community. Most systems in developed countries around the world are looking at improving access to primary care, because that's the best predictor of good health. Access to specialty care does not appear to impact on population health.

To that end, it makes sense to consider the health care system as a single system. Having the LHIN responsible for one part and some other entity responsible for primary care doesn't make a whole lot of sense. There are some political implications of trying to control doctors and I think that there may be some difficulties in implementation, but in terms of planning, we should have a single health care system. The current silos between hospitals and primary care need to be changed in a major way.

The Chair (Mr. Ernie Hardeman): The government: Ms. Jaczek?

Ms. Helena Jaczek: Thank you. I was going to ask the exact same question as Cindy just did, so I'll expand it a little further. I'm a former medical officer of health and I'm wondering what your thoughts are about the integration of public health within the LHIN, how you might see that. Obviously, boundaries might be an issue, but do you, in your promotion of health care to rural

communities—how are you engaged with public health? Could that be facilitated with some sort of integration within the LHIN?

Dr. Karl Stobbe: I've done some international work. I think that some places where populations are particularly well served is when public health becomes better integrated with the primary care system and when primary care takes some responsibility for public health. That would be a significant and major shift. It would require quite a concentration of resources, and I think some sober discussion has to take place as to whether that change is warranted. Better integration between hospital and primary care absolutely has to happen.

Whether some changes need to happen to better integrate public health with primary and hospital care: I think there is some opportunity to make that shift, but I would say it's perhaps not the most pressing issue of our time.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. The official opposition: Ms. McKenna?

Mrs. Jane McKenna: Thank you so much for coming today and for your presentation. We're always grateful for all that you do in the community, so I want to thank you first and foremost.

My first question is going to be this: People always use the word "transparency"—"They need to be more transparent." Can you actually just give me something specific that they need to be transparent about?

Dr. Karl Stobbe: My perception in Niagara is that we have a feeling that we lack resources and that we're disproportionately under-resourced to the rest of the province and the rest of the LHIN. That's a feeling.

We have been in a position to create some innovative program proposals that would be pilot projects that could change the direction of care going down the road and serve as examples to others. I've proposed that to various bodies, including the LHIN, only to get polite encouragement and then find out that health care dollars were spent instead creating a program that had a very well written proposal from a part of the LHIN that's already well resourced, in our opinion—Burlington and Hamilton. The optics of that aren't great, without a whole lot of explanation, except that they're better prepared. Well, they are better prepared because they're better resourced. Then we end up with the rich getting richer and the poor continue to suffer.

I think there is an opportunity to redress that. I don't think the LHINs are constituted to deal with marginalized people. Those in power seem to be able to get more out of the LHIN because they have a voice. That is something, I think, that we need to look at somehow.

Mrs. Jane McKenna: Okay. And then the next thing I was going to say was that Mrs. Scholfield, in her presentation—I don't think you were here to hear that—was just saying that there isn't any consultation at the LHINs. For an example, even though they were speaking about the monies being here, it went over to St. Catharines because she felt there was a cabinet minister there that

encouraged that to go over there. So do you find that the consultation at the LHINs is at the level that it should be?

Dr. Karl Stobbe: I was very impressed with the consultation around planning the future state of our health care system, so planning for what our targets are five years out, 10 years out. I thought the process was remarkable. I thought that the right people were engaged and the mechanisms used allowed for everyone's voice to be heard. I thought that was a remarkably well done process.

In terms of reallocating funding, it's not entirely clear to me—and I've had some interactions with the LHIN; it seems that there are some channels of communication—what money is available, how much and what direction the LHIN would like it to be spent on. When they do allocate money to one project and not another, it's not clear why. So having been on the outside of the funding allocation benefits, I've never been told why we were not funded or why another project was, except of that fact. So I think that there are some opportunities for better explanations to take place.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much for your presentation. We very much appreciate you coming in and sharing your thoughts with us.

Dr. Karl Stobbe: Thank you.

QUEST COMMUNITY HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): Our next delegation is Quest Community Health Centre: Chris Bittle, chairperson, and Coletta McGrath. Thank you very much for coming in to make your presentation this morning. As with the previous delegations, you will have 15 minutes. You can use all or any of that time. Any time that's left over, if it's less than four minutes, will go to the opposition. If not, it will start with the third party, going around using up what time there is spread evenly, if it's more than four minutes.

With that, the floor is yours, and we look forward to your presentation.

Ms. Coletta McGrath: Good morning and thank you, Mr. Chair, and thank you, committee. I am Coletta McGrath. I am the executive director for Quest Community Health Centre. Chris Bittle, our chair, is joining me this morning.

Quest Community Health Centre is a LHIN-funded not-for-profit organization that provides a community-based interdisciplinary model of service delivery, including primary health care, prevention, health promotion and community development. We work with individuals who do not have a primary care provider, and within that context, we focus on marginalized or poor populations who are challenged in accessing the regular health care system. Our model of care includes physicians, nurse practitioners, registered nurses, physician assistants, social workers, dietitians, health promoters, community outreach staff and client coordinators, among others. All of our staff are salaried, including our physicians.

Quest has been delivering services since January 2011. We do so in partnership with a wide variety of organizations, including the Canadian Mental Health Association,

Community Addiction Services of Niagara, the Niagara Health System, Niagara public health, Start Me Up Niagara, Pathstone Mental Health, the school boards and McMaster University's DeGroote School of Medicine, to name a few. This year, we anticipate serving over 3,000 clients and providing over 13,000 visits to those clients. We have several points of service, in addition to our main office on 145 Queenston Street in St. Catharines. We have a community drop-in centre. We have a point of service at a local high school. We also provide services to migrant workers in Virgil over the summer, and we visit clients in their homes. We have now developed two volunteer-based programs, a dental program for marginalized individuals and a chiropractic program.

This morning, as representatives of Quest, we would like to provide the members of the committee with our understanding of LHINs, the rationale for their establishment, their strengths and accomplishments, the challenges and obstacles they face, and some thoughts for the future. Our comments primarily reflect our experience at the Hamilton Niagara Haldimand Brant LHIN from the perspective of Quest CHC.

Before we go any further, we feel it is helpful to provide some contextual information. Governments around the world, as well as across Canada, are at various stages of development and using a wide variety of initiatives to implement new paradigms and structures intended to improve health outcomes. There is a widely held belief that these paradigms and structures show great promise in providing more effective services for clients and improved health overall.

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These initiatives should be applauded, as should all initiatives that attempt to move systems forward, explore how they can be improved, and take the time and resources to evaluate the outcomes and generate strategies for next steps.

In Ontario, LHINs represent one of the government's major strategies to improve health outcomes. They were introduced into the health infrastructure in 2006 through the Local Health System Integration Act. The purpose of the act is to provide for an integrated health system to improve the health of Ontarians through better access to quality health services and coordinated health care in local health systems and across the province. These are laudable goals.

The role of the first partner, the Ministry of Health and Long-Term Care, in this new structural paradigm is to provide strategic leadership, planning and central oversight as the steward of the health system in Ontario.

The role of the newest partner, the LHIN, is to plan, coordinate, integrate and fund specific parts of the local health system. In our case, this local system has the third-largest population of all the Ontario LHINs, encompassing Hamilton, Brant, Burlington, the region of Niagara, Haldimand and most of Norfolk county, and covering 7,000 kilometres.

The LHIN is also responsible for monitoring, evaluating, reporting on and addressing the performance of certain health service providers within their jurisdiction.

Finally, the role of the third partner within this new structural paradigm, not-for-profit health service providers, of which Quest is one: Many community-based health service providers have been delivering services for well over 30 years in the communities for which the LHIN is responsible. Their staff and board mandate is to ensure that local community and neighbourhood perspectives are brought to the table and that community-appropriate, cost-effective and successful services are available as a result. These service providers have also tapped into local leadership, commitment and support—professional, financial and otherwise—as we promote innovation, systems improvement and enhanced health outcomes for our community residents.

CHCs specifically have operated in Ontario since 1974. New funding for new centres has been introduced by all government parties during that time frame. As a result, there are 75 centres, as well as an additional 12 aboriginal centres, across the province. Quest is one of four in the Niagara region.

Serving the greater St. Catharines community, Quest focuses its efforts on individuals with mental health, addictions and concurrent disorders; isolated seniors; members of the lesbian, gay, bisexual, transgender, queer and questioning populations—we do that on a regional basis; people who are homeless or at risk of being homeless; and low-income children, youth and families.

This review of the Local Health System Integration Act would indicate that the government has decided it is time to begin connecting the revised system design with data and information that will inform the progress of the LHIN initiative, demonstrate how well it is working with the Ministry of Health as well as with local providers, and give direction in terms of future steps and if there is a need to revise or amend.

Quest would like to commend the government and the committee on the timeliness of this review and on giving LHINs some breathing space and an opportunity to get a firm grip on their mandate, prior to research or consultation happening.

Achievements to date: Having been established in August 2007, according to organizational theory, LHINs are still at an early stage of development. Much of their initial work has centred on developing structures, processes and relationships. They have done this well, and continue to, seeking input from the community and from LHINs in other jurisdictions.

In addition, when one steps back and considers the new structural paradigm introduced through LHINs and what benefits it brings to the health care table, one sees a number of very positive changes, both from a governance and a service delivery perspective.

I'd like to ask Chris, Quest's chair—he's going to take a look at these changes from a governance perspective first.

Mr. Chris Bittle: Thank you. Since its inception, our LHIN has introduced and supported the introduction of the concept of best practices into governance, serving as a model for those agencies that it funds. For example,

with respect to governance, the LHIN has provided system-wide leadership quickly, despite the challenges of the large LHIN geography; diverse populations; relying on stakeholders, many of whom are not funded by the LHIN—physicians, for example; and having to work with multiple levels of elected governance.

The LHIN has also begun to develop strategic relationships and initiatives to help move local communities toward LHIN-wide goals related to improved quality, client-centred care, innovation, accessibility and accountability—for example, training workshops on quality improvement; workshops regarding aboriginal populations; webinars regarding agency multi-sectoral accountability agreements; and making LHIN staff available to attend board meetings and update members on specific LHIN initiatives.

The LHIN has begun to engage the community at multiple levels in planning and setting priorities for the system, including establishing formal channels for community input and consultation. This was most recently experienced in the development of the LHINs' strategic health plan for 2012 to 2017.

Within the context of planning, the LHIN has begun to align their funding priorities with wellness as well as outcomes related to specific populations rather than illness and the provision of services and treatment, once again as reflected in their strategic plan and in funding envelopes that focus on chronic disease management, keeping residents out of the ER, and aging in place, for example.

There is formal communication-sharing across all LHINs which has increased awareness of what is taking place in different jurisdictions, thus improving their planning capacity and that of the agencies they fund. LHINs have promoted greater transparency by implementing public board meetings and educational sessions.

However, the LHIN faces a number of challenges as well when it comes to governance, and we have summarized a few of these for the committee.

LHINs function in a complex governance environment, with multiple stakeholders and partners. This creates a type of complexity that is new and quite different from your typical corporate or not-for-profit governance experience. The balance required between the independence to generate goals that are relevant to the local community—in Quest's case, St. Catharines and Niagara—as well as take into account those of the broader LHIN-wide system while being accountable to the provincial Ministry of Health and integrating the ministry's vision and priorities into planning as well as funding allocations is challenging to develop and maintain.

This observation regarding the system's complexity emphasizes the need for clarity with respect to expectations placed on the LHIN as well as for the appropriate resourcing, tools and supports to ensure that LHINs can effectively respond to local needs identification, local planning, local service delivery philosophies and local resource requirements while delivering on their system-wide and provincial mandates.

At present, some of the stakeholders needed to effectively plan and support the coordination of the local health

system are not funded by the LHINs. Physicians, family health teams and public health come to mind. So while the LHIN effectively identifies needs and gaps across the health care system, the downside is that the LHIN board does not have the control or authority to address these needs and gaps. The capacity for planning, service design and decision-making that will result in a locally comprehensive and responsive primary health care service continuum is limited by the fact that some health care providers are funded by the LHIN while others are funded by and directly accountable to the Ministry of Health.

Because it is working at a local systems level rather than a provincial level, the LHIN has a strong capacity for relationship-building with community-based service providers. While the LHIN has initiated this process, it does not appear that they have made significant headway at the board and staff level across many agencies. Once again, given their stage of evolution, it may be that relationship-building has taken place with larger organizations, such as hospitals, and will eventually take into account both regionally- and municipally-based organizations and those they represent. The three new community health centres in Niagara, for example, are relatively small compared to agencies that have been operating for some time. This places us at an immediate disadvantage with respect to having our perspective heard. It is also important that staffing at the LHIN be sufficient in number and expertise to support relationship-building.

As we noted, in addition to governance, we would like to speak to the LHIN's impact on service delivery, which Coletta will address.

Ms. Coletta McGrath: The LHIN has promoted principles and service delivery philosophies that have been operationalized by locally based organizations in a variety of ways and with positive results.

Health care has been largely structured and organized around a hospital-centric health care system. Also, it has traditionally focused, to a significant degree, on the needs of health care providers rather than clients. While many health care providers haven't moved away from this model altogether, LHINs are playing a significant role in helping them to do so and move towards a continuum of services that is more heavily focused on wellness and prevention services in the community and less so on the services that hospitals traditionally provide.

Since its inception, the LHIN has been an impetus for agencies to build relationships and a greater understanding of their respective roles. This, together with the LHIN's funding approaches, has created an environment that is becoming more conducive to coordination and change. Working in silos is starting to become a thing of the past. Sharing buildings, spaces and resources—hubs, for example—thinking collaboratively, considering innovative ways to work together, adapting a broader perspective and considering issues from multiple viewpoints are now the common mode of operating.

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While the LHIN has promoted important shifts with respect to service delivery, there are some challenges.

One of these has to do with being the messenger for ministry-wide thinking and priorities, and integrating them into planning and investments across the LHIN jurisdiction, while at the same time being responsive to local needs identification, local planning and local service delivery.

There is also a need to provide a clear message regarding the definition of "integration" and the definition of "local." Integration has multiple definitions. There is a sense that the LHIN is moving from a facilitator and listener to an integration catalyst on behalf of the ministry. Where integration focuses primarily on decreasing the number of funded organizations, thus eliminating or risking eliminating the community-based nature of the health system, it is important to keep in mind that these community-based agencies and boards have played a fundamental role in ensuring the development of services for those who are marginalized and would not otherwise have voices. It is also important to keep in mind that bigger is not necessarily better or less expensive. In fact, it rarely is.

The definition of "local" also deserves some attention. There is a risk that the definition of "local" as it applies to local health integration networks—I remind you, 7,000 square kilometres—will be used to redefine the parameters for local service providers. Ontario's not-for-profit service system evolved over time, has incorporated research and best practices, and is envied around the world. In that system, "local" is defined as community and neighbourhood.

In summary, the new paradigm—the Ministry of Health and Long-Term Care, the local health integration networks and community-based service providers—ensures that the system will benefit from a variety of perspectives. Local agencies represent and promote local and neighbourhood perspectives and needs. The LHIN creates a systemic viewpoint that those local agencies can benefit from; it also has the potential to quickly bring issues of regional importance to a provincial LHIN-based table and to the ministry. The ministry provides an overarching framework that is province-wide, and that enriches and guides the ministry as it listens and supports.

One final observation to keep in mind: No matter how good a new health system paradigm is, for it to work effectively and be supported by residents, people must identify with some component of the paradigm. The average person does not identify with the Ministry of Health and Long-Term Care. The average person, quite frankly, does not identify with the Hamilton Niagara Hal-dimand Brant LHIN.

People identify with municipalities. They identify with St. Catharines. They identify with Fort Erie. They identify with Hamilton. They identify with Brantford. They identify with their local communities. They identify with their neighbourhoods. With that in mind, organizations that provide services at this level need to be encouraged, need to be nurtured and need to be maintained. The LHIN will require the ministry's support from a policy and funding perspective to ensure that this happens.

Quest CHC has a final recommendation, and Chris, our chair, will share it—

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude your 15 minutes—in fact, slightly over it—but we thank you very much for your presentation. I can assure you that you have given copies to the committee; they will read the rest of it and get all the information. We thank you very much for taking the time to come and present to us this morning.

Ms. Coletta McGrath: Thank you.

PLEASANT MANOR
RETIREMENT VILLAGE
MENNONITE BRETHREN
SENIOR CITIZENS HOME

The Chair (Mr. Ernie Hardeman): Our next presenter is Pleasant Manor Retirement Village and Mennonite Brethren Senior Citizens Home, Tim Siemens, executive director. Thank you very much for coming this morning to make your presentation.

Mr. Tim Siemens: You're very welcome.

The Chair (Mr. Ernie Hardeman): As with previous ones—we don't always follow it to the letter, but it's 15 minutes for your presentation. You can use any or all of that time. If you leave some time, if it's less than four minutes, it will go to one caucus; if it's more than four minutes, it will be divided equally among the three caucuses for questions to your presentation. With that, the floor is yours.

Mr. Tim Siemens: I trust that the time is appropriate. I timed it before I came, and it was just around the 15-minute mark.

The Chair (Mr. Ernie Hardeman): Very good.

Mr. Tim Siemens: As was mentioned, my name is Tim Siemens, and I am the executive director of Pleasant Manor Retirement Village and of Tabor Manor in St. Catharines, the Mennonite Brethren Senior Citizens Home. I've been in this role since March 2000.

In addition to my role with these two senior citizens' homes, I also serve on a number of local committees, LHIN-wide networks and provincial boards of directors, including the Niagara seniors' supportive housing network as a member, the Hamilton Niagara Haldimand Brant Community Leaders Council as a member, the HNHB long-term-care-homes network as co-chair, and the Ontario Association of Non-Profit Homes and Services for Seniors, currently as the chair of the board of directors.

Additionally, I have been involved in the LHIN's clinical services plan, the LHIN's Behavioural Supports Ontario committee, and the alternate-level-of-care—ALC—workgroup, and I was a board member of the Niagara Regional Housing board of directors.

Pleasant Manor is located in Niagara-on-the-Lake, and Tabor Manor is located in St. Catharines. We have both private and not-for-profit continuums of care, campuses of care, providing supportive housing, apartments, life-

lease units and long-term care all on the same site, in a range of apartments and life-lease units. The nine-member board of directors is elected annually by the Ontario Conference of Mennonite Brethren Churches.

Our relationship with the Hamilton Niagara Haldimand Brant Local Health Integration Network is captured in two primary agreements. Our individual long-term-care service accountability agreements, or L-SAAs, govern the relationship between the LHIN and each of our long-term-care homes. The multi-sector accountability agreement governs the relationship between the LHIN and each of the homes for the delivery of supportive housing services at both sites. In total, Pleasant Manor and Tabor Manor collectively serve approximately 600 senior citizens.

In terms of the review, to the extent that I am able and based primarily on personal and professional experience, my review of the LHIN will be measured against the objects of the local health integration networks in their role to plan, fund and integrate the local health system as set out in the Local Health System Integration Act, the foundation on which the LHINs were created and implemented throughout the province of Ontario.

Firstly, since its inception, the LHIN continues to promote integration of the local health system to provide appropriate, coordinated, effective and efficient health services. Toward achieving this objective, the LHIN has strongly encouraged health service providers to network and collaborate with each other to identify areas within the health system that can be better coordinated, ultimately to benefit the local population. As a result, the LHIN model has created a supportive environment in which health service providers who would not typically have come together under the former district health model meet and discuss better ways to deliver health locally. It has been exciting to meet other people within the local health system and to work concertedly toward a common aim.

Over the course of time since the LHIN model was implemented, I have witnessed the evolution of the LHIN's role to identify and plan for the health services needs of the local health system in accordance with provincial plans and priorities and to make recommendations to the minister about that system, including capital funding needs for it.

The LHIN model was touted as the pre-eminent model to ensure local planning was encapsulated in local health delivery models. In the early years, many of us health service providers were invited to meet with the LHIN to plan out the local health system. Several years later, provincial priorities, particularly hospital avoidance and responding to ALC pressures within hospitals, came to dominate local service delivery models, making it challenging to fully actualize and realize the local mandate the LHIN model was designed to achieve.

I feel the LHIN has performed highly in its role to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal

channels for community input and consultation. The current CEO and her predecessor, Pat Mandy, strongly encourage engagement of health service providers, either through invitation around a particular purpose or focus, or affirming the formation of like-minded individuals and entities to create functional networks within the LHIN.

I believe the HNHB LHIN is doing a great job in its engagement role. In my capacity as the chair of the OANHSS board of directors, I have had the recent pleasure of touring this fine province, attending the annual general meetings of the nine OANHSS regions. I can share with you that a high LHIN engagement is not always a shared experience across this province. In some cases, it is challenging for health service providers to be given any speaking time with their LHIN. It's not the case here in HNHB. In a model that places such high value on the LHINs to engage their community, this is one area where I would suggest the government make changes.

As an example of the high level of engagement of the HNHB LHIN, I would like to share with you the LHIN's support in the creation of the local long-term-care-homes network. The HNHB long-term-care-homes network was founded in 2006-07 and consists of 87 long-term-care homes within this LHIN. A council of 10 members, representing all 87 homes, meets monthly to discuss shared issues and concerns with the local long-term-care sector within our LHIN. When the LHIN is faced with issues pertaining to long-term care, their first response is to consult this network. LHIN staff attend and participate in discussion with the council. In fact, this model was identified in Drummond's report as the preferred model to be implemented within each of the LHINs across the province.

Without the strong support of the HNHB LHIN, the long-term-care-homes network model would not have received the traction that it has and would not be honoured to hold such high rank by the LHIN and government.

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Additionally, the LHIN, together with members of the Niagara senior supportive housing network and the applied research department from Brock University, has recently completed a set of standardized performance outcome measures that is used by these local providers in effectively measuring the delivery of this vital community service in a consistent and uniform manner.

In supporting this initiative, the HNHB LHIN was able to meet their objective to develop strategies and to co-operate with health service providers, including academic health science centres, to improve the integration of the local health system and the coordination of health services.

I do not feel best equipped to comment on the LHIN's performance to ensure that there are appropriate processes within the local health system to respond to concerns that people raise about the services that they receive. Any comment I could make on this issue would be influenced by recent local media attention on the apparent lack of transparency of our LHIN and comments made about

citizens within this LHIN not even knowing about the LHIN or its existence. I do not share this perspective, as I am fully immersed and engaged within the local health system.

However, I do feel equipped to share that the HNHB's recent mandate that all health care providers within this LHIN incorporate into their operations a balanced score-card approach is a move toward strengthening the relationship between health service providers and their customers. An inherent assumption of this model is based on an organization's focus to better understand and measure its customers' levels of satisfaction in a quasi-scientific manner and establish performance benchmarks from which to launch any number of quality initiatives in an effort to improve customer satisfaction.

While this is a very new mandate and initiative for us, I suspect that in coming years we will collectively be able to better ascertain the performance of our local health system in terms of patient and customer satisfaction. Personally, implementing this approach has brought a breath of renewed energy within the organizations I operate, as we rally together to better understand our customers' needs and improve our service delivery to our customers.

A strong role of the LHIN is to evaluate, monitor and report and be accountable to the minister for the performance of the local health system and its health service, including access to services and the utilization, coordination, integration and cost-effectiveness of services. To accomplish this, the LHIN has implemented a process for health care providers to report quarterly on financial and a range of clinical corridors.

Additionally, when new funding is allocated for special LHIN initiatives—Emergency Department Action Plan funding, Aging at Home etc.—health care providers are required to report separately on these health delivery funding pots, which adds considerable administrative burden to the organizations. Couple this together with the reporting requirements of the Ministry of Health and Long-Term Care, and it should be no surprise that health service providers are growing increasingly weary in responding to the high burden of reporting within the health system.

As an operator and member of OANHSS and its board of directors, it is our hope that through this process of review, action will be taken immediately to seek ways to reduce the administrative and reporting burden of health service providers.

The LHIN is responsible to participate and co-operate in the development by the minister of the provincial strategy and in the development and implementation of provincial planning, system management and provincial health care priorities, programs and services. From the perspective of a health service provider in long-term care and supportive housing, we see by experience how the LHINs have worked with the minister in establishing the L-SAA and M-SAA agreements to fulfill the system management piece of this broader mandate. While this methodology has, at its broadest level, been successful in

standardizing the formal relationship between the funder and program providers across the province, we have seen numerous examples of inconsistencies across the LHIN in the context of performance outcome indicators within these agreements.

For example, in most agreements, the quality agenda forms an inherent standard component of the LHIN's and ministry's interest to improve quality within the system to the highest degree. This is something no one can, nor should, contest. We are all interested in creating the highest-performing health system. However, in some cases, LHINs have incorporated into their agreements mandatory clauses forcing organizations to become accredited. Mandating something that is typically optional for organizations will place undue financial burden and hardship on organizations required, through their formal agreement, to become accredited.

In summary, going forward, it will be important for the ministry to ensure there is a consistent approach in the delivery of health services by all LHINs, particularly when it impacts funding and limited resources, as it will create inequities in service delivery from one provider to another. Imposing conditions that take added resources will impact the provider in providing the same service as another home that does not have the added financial burden.

Another object of the LHINs is to allocate and provide funding to health service providers in accordance with provincial priorities so that they can provide health services and equipment. I have witnessed the concerted effort of the HNHB LHIN to allocate funding toward hospital avoidance and reducing ALC levels, from which the organizations I have and other organizations have benefited. As a result of this funding and focus, we have been able to increase capacity for housing and supportive housing, which will help many more seniors stay in their homes longer and out of hospitals and long-term care.

As an operator, it has sometimes been a challenge responding to the LHIN's requests for proposals for new funding, based on the speed at which funding announcements are made and the expectations of turnaround times. However, the LHINs' timelines appear, in many cases, to be a function of how quickly the LHINs need to respond to the government's announcements for funding for LHINs.

The LHIN has worked effectively to enter into agreements to establish performance standards and ensure the achievement of performance standards by health service providers that receive funding from the network. In the context of the M-SAA, when it was in its formative stage, we were invited to meet with the LHIN to work collaboratively to establish reasonable clinical performance corridors and standards. Since that time, our processes have evolved to refine our approach to performance measures up to and including the shared development of a standardized set of quality outcome measures for supportive housing, as previously described. Also, as previously mentioned, the mandated balanced-scorecard approach will assist health service

providers to establish additional performance benchmarks from which to launch intentional quality-based strategies to improve overall satisfaction within the health system as a whole.

In closing, I would like to paraphrase a brief talk I heard presented at a past OANHSS convention by Hugh MacLeod, the then associate deputy Minister of Health, who likened the LHIN model to a parade. At the parade, there are many people playing different roles. There are floats at the front of the parade, there are floats in the middle of the parade and there are floats at the end of the parade. There are spectators standing on the sidelines watching the parade go by. Each person in attendance plays a particular role of engagement. Some are content to be involved, while others are content to just watch. The LHIN model is like a parade. To make the LHIN model successful, we must be fully engaged in the parade, for if we are not and remain content to sit on the sidelines as spectators, the parade will pass us by and we will have lost the opportunity for involvement and influence in shaping the excitement of the parade and the parade itself.

Perhaps there is not one successful model for the delivery, funding and management of a health system, particularly one that is so highly complex. The province of Ontario was the last province to embrace and implement a regional health model. In their effort to move toward a health system that responded directly to local health needs, the government of the day implemented the local health integration network model. This model is by no means a perfectly running example. Since its inception, there have been much evolution and challenge in getting it to the state where we see and experience it today.

My experience and professional involvement leads me to believe that we still have a long way to go in tweaking this model to achieve its stated mandate and result. Personally, it has been a pleasure for me to be encouraged and welcomed to join the parade and to participate in shaping the delivery of health in my community.

I thank you for this opportunity to present to you my perspective as part of that journey.

The Chair (Mr. Ernie Hardeman): I should have taken your word for it when you started: It was 15 minutes. Thank you very much for your presentation. It's much appreciated.

Mr. Tim Siemens: You're very welcome.

PATHSTONE MENTAL HEALTH

The Chair (Mr. Ernie Hardeman): Our next presenter is Pathstone Mental Health: Ellis Katsof, chief executive officer. Good morning. Thank you very much for coming in. We have the presentation here that the Clerk will pass out to the committee. Thank you very much for coming in. You will have 15 minutes to make your presentation. At the end of the 15 minutes—you can use all or any of it—if it's more than four minutes, we'll have questions from each caucus. If it's less than four

minutes, we will give it to the official opposition caucus for the four minutes. Thank you very much for coming in, and the floor is yours.

Mr. Ellis Katsof: Thank you very much, Mr. Chair and committee members. I appreciate having the opportunity to be here today.

Pathstone Mental Health is a not-for-profit mental health agency for children and youth from birth to their 18th birthday, and their families. We have been in this community of Niagara since 1968. We are in our 46th year providing services to the community. Pathstone Mental Health is funded by the Ministry of Children and Youth Services and is the only accredited children and youth mental health agency serving all of Niagara region. Last year, Pathstone served 7,362 children, youth, adults and caregivers, who received almost 32,000 treatment sessions.

Adult mental health services are provided by agencies funded through the LHIN and are for individuals once they turn 16 years of age. Therefore, there is an overlap for 16- and 17-year-olds. We call this group the transitional age group, with one foot in children and youth services and the other in adult services.

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Our agency works in partnership with adult mental health agencies to serve this transitional age group. We also work closely with addiction agencies which are also funded by the LHIN and deal with this transitional age group. The LHIN recognizes the overlap between funders and service providers, and encourages inter-agency collaboration for this challenging transitional age group.

Niagara is in a unique situation at this moment in time. Niagara has the highest unemployment rate in Ontario, the highest low-income levels, the highest percentage of seniors in its population, one of the highest obesity rates in the province, a very high intensity level of child mental illness etc. All of these indicators affect our citizens' health. This alone is a very strong argument for health planning at a local level.

Although the Ministry of Health and Long-Term Care is responsible for setting provincial policy, standards and strategic directions, the LHIN is then able to take into account local needs and receive input from residents and service providers and integrate this information into local health plans that not only address provincial standards, policies and strategic directions but also take into account local issues and needs. From my perspective, as a partner with these adult mental health and addictions agencies that are directly funded by the LHIN, the LHIN fulfills this role well.

Another reality that makes the LHIN important to our community is the geographic size of Niagara. Niagara is 296% larger than the city of Toronto, which makes it very challenging for service providers to meet the needs of Niagara residents. The local planning perspective brought to Niagara by the LHIN helps create decisions that address these geographic challenges.

There are no simple solutions to delivering services across Niagara. The LHIN has worked diligently, I be-

lieve, at encouraging ongoing community engagement and input from residents and health providers across Niagara into each planning priority that it addresses. This would be very difficult to accomplish at a provincial level.

The one area that I would like to highlight for your consideration when reviewing the LHINs is the policy that the LHINs will not fund any new agencies. Although in principle this policy makes sense, I believe some flexibility is required when implementing it. Both the Ministry of Health and Long-Term Care, through the LHINs, and the Ministry of Children and Youth Services fund mental health services. Last year, Pathstone provided treatment to almost 4,500 children and youth; 50% of those children and youth had at least one parent—one adult—with a mental health challenge. Although it makes sense to provide seamless treatment to the entire family—both parents and children—due to funding anomalies, Pathstone is only able to access funding from the Ministry of Children and Youth Services to provide treatment to the children and youth, while funding to provide treatment to the parents, available from the LHIN, is not accessible to Pathstone Mental Health, forcing the parents to go to a completely different provider.

Here is another example where being unable to apply for funding from the LHIN does not make sense to our agency. The Niagara LHIN's mental health and addictions 10-year strategic plan includes the following proposed strategy: Stop stigma—bring mental health and addictions out from behind closed doors.

In 2013, the LHIN issued a proposal call addressing the LHIN's mental health and addictions strategies. Three years ago, Pathstone Mental Health took the lead in developing a community-wide anti-stigma campaign. Pathstone struck a community advisory committee comprised of 35 Niagara professionals and community members who developed the anti-stigma campaign called Shatter the Stigma Mend the Mind. Adult mental health agencies are among the members of the community advisory committee. Although Pathstone Mental Health has taken the lead role in implementing the anti-stigma campaign, it was ineligible to apply for or receive LHIN funding through the LHIN proposal call because it was not a LHIN-funded agency. To the LHIN's credit, they did encourage us to put the proposal in just to keep them aware of what we were doing, but no funding followed. No allowance was taken into account that Pathstone has been a provincially funded agency for 45 years, currently through the Ministry of Children and Youth Services—although originally it was funded through the Ministry of Health, until ministries were changed and all the children's services were moved into one ministry, so we do have our roots in the Ministry of Health—nor that it has a working relationship and a strong partnership with the adult mental health sector on our anti-stigma campaign and in the services that we deliver to the transitional age group.

In closing, the LHIN states that it “works with other stakeholders, including primary care providers, housing

providers, health and social services and other funders to help link care and supports for healthy people and healthy communities.” From my experience as CEO of a children and youth mental health agency funded by the Ministry of Children and Youth Services, the LHIN works hard at linking funders and other service providers so that care and supports for healthy people and healthy communities can be a reality in Niagara. They fulfill a role that is challenging and very crucial to the residents of our community. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will have enough time for two minutes from each party. I think we start with the third party.

Ms. Cindy Forster: Thanks for being here today. I’ve heard from a number of presenters today, and a couple of them fed right into your comments about the high unemployment rate, the high number of seniors, the fact that parents with mental illness and children with mental illness are not being seen together, and the lower income levels for families here in Niagara. There was a suggestion that there’s a sense that Niagara is kind of the poor sister, whether it’s within the LHIN or across LHINs. Can you give me some comments on that?

Mr. Ellis Katsof: I’d have to agree with a previous speaker—I was here for the past few speakers—that it is very difficult to get concrete statistics on funding on a per capita level, whether it’s for children’s mental health, adult mental health, hospitals or other types of services. Statistically, in a concrete way, I cannot say absolutely; in a perceptual way, the entire not-for-profit sector—or all the colleagues that I work with all have that perception that Niagara is underfunded on a per capita basis, no matter which sector you look at. When we have local planning bodies like the LHIN, hopefully that will be an opportunity to begin rectifying that in the future, but there has always been a feeling that once you cross that Skyway, somehow, Niagara is the forgotten poor sister.

Ms. Cindy Forster: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. The government, Ms. Cansfield.

Mrs. Donna H. Cansfield: Thank you very much for your presentation. It was very well received and very balanced.

Mr. Ellis Katsof: Thank you.

Mrs. Donna H. Cansfield: I’d like to ask about the transition times. One of the biggest issues we have is when young people turn 18 and then they hit that adult wall, barrier, transition or whatever you want to call it. In fact, if what you’re proposing were to occur, we could eliminate some of that, because you could transition over. I really would be interested in your perspective on how we could do that. How do we move forward on this?

Mr. Ellis Katsof: There are a number of different transitional points. As I mentioned, in the health sector, one becomes an adult at the age of 16. In the Ministry of Children and Youth Services sector, you become an adult when you turn 18. If we look at international theory and if we look at brain development theory, people are not

really considered an adult until they’re 24 or 25, and governments around the world are beginning to plan their services for children and young adults up until the age of 24 or 25.

Ontario and Canada lag behind. It’s a major challenge, from a policy perspective, when you have ministries that are structured, often, with age guidelines. It is a significant challenge to take that into account and make those changes, I believe, over time. Not in my career, but over the next 20 years, I think that is the way we will see things go in Canada, because it’s happening around the world.

In a small way, how could that happen? As I mentioned—and I’m just talking about mental health—if children’s mental health services could be funded by both ministries, then that would allow agencies to have services across the lifespan and deal with that transitional age from 18 to 24, because we would be able to get funding for mental health services for that age group and then have a seamless system.

If we’re able to get services for adults as well, for the parents, then we’d really have an integrated system, because in systems theory it’s much easier to deal with children and families who are both dealing with a depression disorder, because the children go home after therapy, and if the parents aren’t dealing with their depression disorder—if one of the parents has one—then it’s really difficult. You’re going back into a home where you’re surrounded with certain behaviours that reinforce the behaviours.

All it is, in learning to deal with depression as an example—you have to develop the strategies to deal with your depression disorder, because you’re going to have that your whole lifetime.

The Chair (Mr. Ernie Hardeman): Thank you very much.

Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation, Mr. Katsof, for being here today and for the wonderful work that Pathstone is doing in the community for children and youth.

Mr. Ellis Katsof: Thank you.

Mrs. Christine Elliott: You’ve raised some really interesting points. One of the things that we talked about—Ms. Jacek and I had the pleasure of sitting on the Select Committee on Mental Health and Addictions a few years ago, and we noted some of the concerns about having children’s mental in one ministry and adult mental health in another ministry. We ultimately recommended that it be folded into the Ministry of Health, with some inter-ministerial co-operation.

But I think for the purposes of what’s going on with this committee, you’ve really raised the issue about having some important parts of health care being outside of the LHINs, and it looks like children’s mental health—just because it’s in a different ministry—isn’t being included.

Children’s treatment centres, I think, are another valuable component that also aren’t included.

So would you recommend that we include all of the service providers, particularly, in your case, children’s

mental health? Obviously, you're advocating for some funding, so I'm assuming you feel that it should be rolled into LHIN funding and resource planning.

Mr. Ellis Katsof: I won't comment on which ministry children's mental health should be in. I think that's a political decision. I don't think there's any right ministry that children's mental health should be in, but I think there's a much easier way of accommodating the funding anomalies, that children's mental health agencies should have access to funding from both ministries. There are very strong arguments for it being in either ministry, and I think it really would end up being a political decision rather than a rational decision, because there are good arguments on either side.

It's a simpler way of just allowing funding to flow. And if funding flowed to the children's mental health sector from the Ministry of Health for the adult portion, then the children's mental health sector would also have to come under the planning responsibilities of the LHINs, as it comes under the planning responsibility of the children's mental health sector.

Both ministries are working very, very diligently at the policy level and the senior bureaucratic level to do cross-planning around children's mental health already. Our ministry is working very closely with the Ministry of Health around planning issues, so I think it would be a much easier fix as far as having funding accessible from both ministries.

The Chair (Mr. Ernie Hardeman): Thank you very much. Just before we say thank you for coming in, I would just like to point out that I've heard it a number of times in the deputations this morning, and I'll take the Chair's prerogative: I totally agree. I don't come from the Niagara region but we, too, think we're being short-changed in all these services.

Thank you very much for your presentation.

Mr. Ellis Katsof: Thank you.

The Chair (Mr. Ernie Hardeman): And with this, the committee is recessed.

The committee recessed from 1156 to 1259.

NIAGARA HEALTH COALITION

The Chair (Mr. Ernie Hardeman): We'll call the meeting back to order. I hope everyone noticed that our lunch did not include turkey, because turkey has a habit of making people sleepy after lunch. I wanted to make sure we were all bright-eyed and bushy-tailed.

Interjection.

The Chair (Mr. Ernie Hardeman): Now you're getting so technical.

Anyway, thank you very much for coming back. I think our first delegation is at the table. Our first delegation is from the Niagara Health Coalition: Ron Walker. Thank you very much for coming in.

Before we start on it, I just want to point out to the committee that the 1:30 delegation has called in and, because of the weather, is not going to be able to be here today.

With that, Ron, we get back to you. As we have done with the others, you get 15 minutes to make your presentation. You can use any or all of that time. If you leave less than four minutes, we will have one party ask questions and comments. If it's over four minutes, we will divide it in three and have each party have an opportunity to question. If you use it all, we won't have to do either. With that, when you have two minutes left, I will just go like that. But with that, thank you very much for coming in, and we look forward to your presentation.

Mr. Ron Walker: Thank you. You should have copies of our presentation in front of you, but I'm just going to have a sort of stream-of-consciousness introduction here.

Dear members of the standing committee conducting a review of the form, function and legal competence of the local health integrated networks: Ultimately, the delivery of health care in Ontario is your responsibility, and perhaps the LHIN is the best way to do this. Your review will determine this.

First, I must mention the importance of having a new health care accord to ensure federal participation and health care delivered by this and other provinces. Second, I draw your attention to the Canada Health Act and its provisions to provide seamless and roughly uniform health care throughout every jurisdiction in Canada. Third, when considering the long-term projection of health care delivery, I am forced to ask you to reject the arbitrary 1% increase in spending limits under the austerity budget, because it's unrealistic going forward.

Perhaps the most salient point to make when discussing the LHIN system is its transparency and accountability. We were happy to see the local LHIN, an area much larger than the Niagara region, recently announce that it will post relevant information about its decision-making process online. But why has it taken so long to get to this point?

Our local LHIN is not even operating with a full complement of board members, and I don't believe it ever has. How can local interests be represented on the board? This is unacceptable. When there is a full board, I believe it would be wise to have a delegated citizens' advisory committee to recommend to the board ways to meet a broad range of health care needs. Of course, the LHIN's function would then not only be disbursing funds within the existing framework of health care delivery but recommending, itself, ways to improve health care delivery to the ministry.

I must mention the political games being played with respect to a new hospital being built to replace existing ones in this area. This made the Globe and Mail, so it's of national interest. The Niagara Health Coalition rejects the views of some journalists, who misrepresent the question of access to services as simply a political gambit of the NDP. Access to service is a fundamental demand of the citizens of Niagara, even as represented by their city councils at Welland and Port Colborne.

Just recently, a 20-year-old man's life was saved by the quick action of friends and paramedics. He was gotten to the Welland emerg in five minutes and resuscitated

after an hour. We do not know if he would have survived a trip to the Falls. Fortunately, we don't need an inquest to determine it.

A few years ago, there was an inquest that determined, in that case, that it made no issue; the amount of time getting to any of the facilities in the area wouldn't have made a difference. But that case did raise the issue—which hasn't been addressed yet in all the reforms being talked about—of the need for a trauma centre in our region. I think the LHIN has missed on that, because they don't hear what the needs are.

Speculation is that we can link with Buffalo and deliver all the trauma cases there, and I don't really find that a reasonable solution. I think that for trauma cases that occur in Canada, it's good to have the access here. If special care is needed, then Buffalo accessibility is good. I think the two countries should co-operate, but it shouldn't be the baseline.

Our hospital foundations are merging, and that's good, because we know that they provide for the medical equipment which goes into our hospitals. The LHIN really doesn't play any role in that. The foundations have to raise money and come up with that for the equipment to put in the buildings to allow the health care to be delivered, and I don't see any changes on that front.

Recently, new funding has been provided to the local LHIN which will slash home care waiting lists and provide more retirement services, but remember that most of these are provided by privatized companies and, really, there is little oversight over them.

The government announcement of this increased funding was made—to show you the disconnect—in the middle of a home care workers' strike, when those services were not even being provided. They make an announcement about expanding the provision of health care services, and the ministry is so out of touch that they didn't mention, "But we can't do anything at this time, because the community care access can't refer anybody, because no services are being delivered right now, because the Red Cross workers are out on strike."

That has been resolved, to a point, because they're going to use the other traditional health care services' arbitration procedure. So, hopefully, that will be resolved in this area as well as across the province.

Finally, there are many other issues. Maintaining existing services using the Welland operating room: When the announcements were made in St. Catharines, access to the Welland hospital operating room dropped, because people thought it was closed. They actually had to make an appeal—"Book your operations in the Welland operating rooms, or they'll have to close"—because if you can't operate, you can't provide anaesthetists. If they can't work, then the whole operating room will be shut down. We don't want that shut down until it absolutely has to be, and we actually don't want it shut down at all.

Birthing services: There's some progress there. I don't know the role the LHIN is playing in that, but there will be a role because if they develop the ongoing birthing services, the LHIN will fund them. It will be a new format.

Shared services are being developed in St. Catharines under the NHS, and it's been approved by the LHIN. When they build that new hospital, it wasn't mentioned that the health care providers are actually not going to move from Hamilton or other places to here, but they'll work out of Hamilton and come down here and deliver those services. That may be a synergy but I don't know if it's the best synergy. At least there is treatment close to home right now.

Along with that, you know we've recently had a new CEO appointed to ours, and he happens to be also the CEO of St. Joseph's, so we don't know if that will be a case of one CEO means, really, you have now one hospital system, not separate hospital systems.

If we look locally, Port Colborne is stressing very hard in the review, where are these urgent care centres that are promised? What's the information forthcoming on those? There are improvements in family doctor areas, so hopefully a LHIN will do that and won't let those services go into private networks.

Public health raises the issue of dental care; that's something not provided for. Maybe if LHINs were hearing input about community health, they could make some recommendations on that, because it costs the ministry more money down the road to treat people whose teeth are deteriorated and as a result they have more serious health problems.

Finally, there are externalities: You can make the best plans but other governments in local areas also have budgets and these things. When they built the new hospital in St. Catharines, an idea was put forward of having a third street access because there was already congestion on Fourth Avenue where the new hospital is. Now we see that's postponed because they had to build a new bridge, Burgoyne Bridge, over the Twelve Mile Creek, so the new exit from the QEW is going to be in the next 10-year program. A decision like that may affect long-term health care delivery.

I think, basically, we're saying that the LHINs should play a more proactive role in inputting information into itself and then forwarding that information to the ministry, and not just simply deliver services within the existing health care framework according to a budget set by the ministry, and then including all kinds of mergers and cost savings as its main feature, instead of really expanding the delivery of health care. That's essentially what our local health coalition wants to bring to your attention.

The Chair (Mr. Ernie Hardeman): Okay. I don't know who to start with here. We have five minutes. We'll have a minute and a half from each one. We start with the government party: Mr. Colle.

Mr. Mike Colle: Okay, thank you.

So overall, you're generally supportive of this local decision-making structure through the LHINs, as opposed to having everything centralized in Toronto.

Mr. Ron Walker: Essentially, yes, but it needs that added sort of citizens' advisory committee created that could put input—

Mr. Mike Colle: Yes, so that citizen advisory function has to be more formalized, right, in the structure?

Mr. Ron Walker: Yes, locally—on the board, there seems to be only one person. She works in aboriginal health, so I know the aboriginal health needs are being addressed because they have a member on the board who is serious about addressing those questions. But I think they have five out of nine potential board members, so just even on the board itself, there's room for a lot more community input.

Mr. Mike Colle: In a formal way.

Mr. Ron Walker: In a formal way. I think, in a formal way, they really need to create some structure of a citizens' health assembly that would get together and discuss and make recommendations that they would send to the LHIN, and then the LHIN could take the information they're garnering through this process to the ministry and make recommendations.

Mr. Mike Colle: And as you know, Dr. Smith has recommended, I guess, that there be a new regional comprehensive hospital built in Niagara Falls. Is that a problem for Niagara region, to have it built there?

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Mr. Ron Walker: There's no problem with a hospital built there to service all the communities along the river. It doesn't adequately service the main part of Niagara south, which is Port Colborne, Welland and Wainfleet, and that's just within the Niagara region. Remember, the LHIN actually deals with that Haldimand district too, so if the Dunnville hospital closes down there won't be any medical facility in a huge rural area. That's a rural community basically. And I gave just one example where, if we didn't have a Welland hospital, there's a young man who might have died going down to Niagara Falls.

The Chair (Mr. Ernie Hardeman): Okay, thank you. The official opposition, Ms. Elliott.

Ms. Christine Elliott: Thank you very much, Mr. Walker, for coming to the committee today and for your presentation. You mentioned that you weren't against the idea of the new hospital, but what do you think about the existing hospitals? Do you concur that there should be urgent care centres or would you rather see two fully functioning hospitals still out there in addition to the new hospital? What's your view of that?

Mr. Ron Walker: My own view, and this is my view, not necessarily the coalition's view, is that because of our area and geography, we could use three full-service hospitals. That would mean not closing the Welland one now or any time soon and actually making provisions long-term, let's say within 25 years, to have a hospital in that area of the region built. But again, it's long term. This new hospital in Niagara Falls, it will be probably 10 years before it materializes. But if everybody thinks the Welland services are already shut down, they will get shut down, so we don't want that.

There are other ideas. Some people propose to turn it into an ophthalmology centre, which would be okay as long as it's not privatized. Other people are saying Welland hospital could be converted to one of these birthing

centres I've talked about. There are no specifics about the urgent care centres, but that would be an option, that Welland could become an urgent care centre for the next 25 years until it has to be replaced. There are many options, but they're not for consideration. All the excitement is sort of about the Niagara hospital. And then the announcement appears in the Globe and Mail. This announcement means five hospitals in Niagara are closing, and we don't agree with that.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. The third party, Ms. Forster.

Ms. Cindy Forster: Thank you, Chair. Thank you, Ron, for being here today. I'm glad you raised the issue of dental care because we all know that dental care can lead to many huge medical issues. Are you suggesting that the current dental care programs that are administered perhaps through community and social services or the Ministry of Health should be part of the mandate of the LHIN?

Mr. Ron Walker: Anyway, the LHIN can't take that power unto itself, but I do think the Ministry of Community and Social Services should look at that question. If you study politics, the first thing they say is that the biggest communication gap is between the ministries. All the ministries operate independently, they all fight for their little piece of the budget and there's no wide, comprehensive—but it would save money for social services and for health care if that kind of dental care was provided.

There is a little truck that goes around that does a little bit—you know, a little van. The statistics still show that a lot of cases show up in the Niagara Health System because people haven't had proper dental care.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you coming in.

Mr. Ron Walker: I had just one thing briefly, and it's just a concern. Pathstone Mental Health made a presentation. I wasn't here for that, but I'm concerned because the new hospital is providing a wing for mental patients—quite a big wing—and facilities and so on. And then a short time later, it's announced there will be a big, new building, Pathstone Mental Health, which is a not-for-profit, but still, it's private health care delivery. Will people in that facility have the protection they would in—

The Chair (Mr. Ernie Hardeman): I appreciate the question, but I think it goes beyond the scope of our hearing today, as to what they're going to do with individual hospitals. But we thank you very much for your presentation.

Mr. Ron Walker: Thank you very much.

NIAGARA SOUTH WEST HEALTH LINK

The Chair (Mr. Ernie Hardeman): Our next presenter is Jeff Remington from the Niagara South West Health Link; I should say Dr. Jeff Remington. Thank you very much for coming in. We welcome you. As with the

others, you will have 15 minutes to make your presentation. You can use any or all of that time. If you have any time left over, if it's less than four minutes, we will give it to one caucus. If it's more than four minutes, we will split it between three caucuses for any questions or comments they may have to your presentation. At the two-minute mark, if you're still speaking, I'll put up my fingers to let you know that you have two minutes left.

With that, the floor is yours. Thank you.

Dr. Jeff Remington: Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to speak today to you.

I'm a family doctor. I grew up in the town of Fort Erie here several years ago. I've been practising family medicine in the city of Port Colborne for 19 years. I also practise emergency medicine in the Fort Erie hospital, in the Port Colborne hospital, in the Welland hospital and also in the Dunnville hospital. So I have a bit of a unique perspective as a front-line care provider that I'd like to share with you today.

I have also been teaching medical students, family medicine residents, physician assistant students and nurse practitioner students since 1997. I know my colleague and friend Dr. Karl Stobbe from the Niagara campus of McMaster came and spoke to you this morning and made comments about the important role of education and how the LHIN can work with that.

Let me start off by telling you a bit about a case that I think highlights a lot of my perspective on the LHIN. I was in the Dunnville emergency—Haldimand War Memorial Hospital emergency—approximately a year ago. Brought in to me was a nice older fellow, about in his eighties, who was having back pain. He'd been seen by his family doctor in Hagersville and had X-rays done, had not heard the results of those and, because of worsening back pain, came to the emergency to seek care. Clearly, he was distressed, and my goal was to both alleviate his pain but also find out what was going on.

I was able to pull up his X-rays on ClinicalConnect, a computer program that links all the hospitals' data in the LHIN, because he'd had those X-rays done at the Hagersville hospital, the West Haldimand General, and I wasn't happy with what I saw. I felt he needed a CT scan to further investigate was going on in his spine.

At the time, we were sending patients from Dunnville to the Welland hospital for CT. So I was able to pick up the phone, call my colleagues in the Welland radiology department, transfer the patient by ambulance to Welland for a CT, bring him back, and, unfortunately, those CT findings did not show good things. He had cancer in his spine.

A new program had just been set up called ED Critical Link. Through the CitiCall program, the Haldimand War Memorial Hospital had been paired with St. Joseph's hospital in Hamilton. I was able to pick up the phone and with one phone call be patched through to the emergency physician on duty at St. Joseph's hospital in Hamilton, have the patient transferred there to obtain urgent consultation with a spinal surgeon in Hamilton and refer on

from there to the Juravinski cancer hospital on Hamilton Mountain.

Unfortunately, the end result was that the patient was not able to be cured, and he did pass away from his cancer. But the family of the patient wanted me to come today and talk to you about his case, because they felt it illustrated a lot of the good that the LHIN can do and has done, but it also illustrates a few of my frustrations with the LHIN.

So, as I said, I'm a family and emergency doctor from the city of Port Colborne, and that day I was working in the Dunnville emergency. Why was I in Dunnville emergency? Well, because in 2009, based on the hospital improvement plan of the Niagara Health System, which was endorsed by the LHIN, they downgraded the Port Colborne hospital into an urgent care centre and a chronic care facility. As a primary care physician, as someone who loves emergency medicine, I chose to continue my emergency medicine career by looking at the neighbouring hospitals and continuing to provide emergency care there.

My first introduction to the LHIN was not that great. I remember the former chair, during public consultations on the hospital improvement plan in this community, actually telling the community that Fort Erie and Port Colborne do not have emergency departments—this was in 2008 and 2009—they do not have emergency departments, and they never have. Personally, I was quite flabbergasted that such a senior official in health care could have been so arrogant and so ignorant to actually self-define emergency departments.

The fact was, the ERs in these cities were thriving. They were not as equipped and as staffed as, say, the emergency departments in the three larger cities, but as we all know, there are emergency departments in this province that see 10 patients a day, that are staffed by nurse practitioners, that don't have CT scans, that don't have specialist access. So, certainly, the first impression I had of the LHINs was that they were very heavy-handed, ill-informed organizations.

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My good news today is that that impression has changed. Several years ago—two years ago—I was approached by the leadership of the medical school, Dr. Stobbe; the mayor of Port Colborne; and Dr. Everson from our LHIN, asking me to set up a program called the Port Colborne Interprofessional Care Project, which personally I like to think is a bit of a prequel to the current health links project. We were asked to bring community providers together for the purpose of providing services to those patients who had high-demand care who seemed to be falling through the cracks and who seemed to have difficulty accessing community services.

I'm happy to say that our trial project worked very well. A wonderful example is the Port Colborne memory clinic, which has been running for a year now. It's a collaboration between my clinic; the Niagara Health System, who for a year provided a nurse practitioner; the Alzheimer Society of Niagara, which provides a social

worker; a local pharmacy; and the McMaster campus in Kitchener-Waterloo, which provided the training and mentorship. This program provides excellent, broad-based, community-based care to patients with declining memory and their families, who are clearly distressed as they are reaching this phase in their life. It's a great example of how the LHIN has helped facilitate bringing parties together all with the same goal but now under one roof providing care to vulnerable patients.

As was stated in my introduction, from this, I'm now working with the LHIN on health links. I am the primary care lead for the Niagara South West Health Link, which takes into account the municipalities of Pelham, Welland, Port Colborne and Wainfleet. We're currently working on our business plan, and I would say that there are a lot of very exciting initiatives in there that will certainly help the 5% high users in this area and also, I think, lay the groundwork for care programs that will change the face of health care in at least our health link for quite some time.

We're certainly co-operating and collaborating with the other two health links in the general Niagara region as well as the North West Niagara Health Link, and we are looking at projects to collaborate with our Haldimand partners in the Haldimand Health Link because, as the previous speaker said, the LHIN does incorporate a large geographical area.

As my patient example showed, the traditional lines of care, such as, "You're in Niagara only," "You're in Haldimand only," "You refer to Hamilton," are no longer there anymore. They're definitely blurred. Patients in Niagara seek care in Haldimand. Niagara is responsible for the care of patients in different jurisdictions, as is Hamilton. I would say that the health links project shows just what the LHIN can do when it's actually given the resources and the mandate to do good things for care.

In the end, I think caution does need to be waived at the LHIN. Unfortunately, there is still some disparity in the care that's provided throughout the LHIN. I know that with our Port Colborne project, resources are hard to obtain when you are a small volunteer organization that doesn't have access to the type of health policy writers and bean-counters that can help you make the grand proposals that the ministry likes to see in order to get funding for projects. My fear is that I still see lots of funding going to the larger organizations and maybe not to the small grassroots organizations, just because we don't have the infrastructure to make the proposals that I know governments like to see, especially in fiscally tough times.

I see the LHIN staff getting bigger. I am privileged to work with some excellent and fantastic health care planners and leaders there. But again, as with any bureaucratic organization, one has to be wary when it starts to get large and oversized and the cubicles get smaller and smaller at the Grimsby office.

I have worked with the district health council in the past on physician human resources, and great things came out of that work, including reforms to the under-

served area program, the minister's Expert Panel on Health Professional Human Resources that eventually led to the building of the satellite med schools, and the changes that we've seen in health human resources today. I think the district health council was a great grassroots organization.

I want the LHIN to carry on with that transparency and that community involvement, ensuring that it's not only people who are experts with diplomas on the wall but that they actually get grassroots involvement. The LHIN needs to be accountable to patients, to front-line providers, to the local health care leadership and also to the provincial ministry, and they need to remember that mandate.

I see their role as providing equity and accessibility across the LHIN. Just because a patient presents to the smallest emergency department or to a small front-line care provider doesn't mean that they shouldn't have the same access—maybe not at the same time, maybe not at the same location, but they should have access to all of the care that someone who presents to the largest emergency department has. It may mean transportation or it may mean getting patient advocates involved to get them there, but they should have that same accessibility.

The patient that I told you about: Due to great computer linkages like ClinicalConnect and program linkages like ED Critical Link—the LHIN was first-hand in making those happen, and I think that's a great example of the LHIN at work. Thank you again for your time today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have about six minutes left. With that, we'll start with the government. Ms. Sandals—oh, Ms. Cansfield.

Mrs. Donna H. Cansfield: One day, after 10 years, he's going to get this right.

It's okay, Mr. Klees.

Laughter.

The Chair (Mr. Ernie Hardeman): I'll never be forgiven.

Mrs. Donna H. Cansfield: Anyways, thank you. I really appreciated your presentation. It's refreshing to have someone who looks at this with sort of a clear vision in terms of the patient, which is really what it's all about at the end of the day.

I have the pleasure of having four LHINs in my constituency, so I'm well aware of the variance in standard of care. I would really appreciate hearing from you how you think we can find some process or some means—or does it have to be dictated? I recognize there's need for flexibility, but I also recognize there needs to be a standard of care, provision of care, for equity and equitable service across the different LHINs. Have you got any ideas?

Dr. Jeff Remington: Thank you for the question. I think we have to think about what equitable means. Does equitable mean that if I walk into the Dunnville hospital with a heart attack, I'm going to have a cardiac catheterization lab available at my disposal at that hospital? Or

does it mean that the system will be in place so that the emergency physician, recognizing the patient is having an acute myocardial infarction, will have an effective, efficient, fast and transparent network that gets that patient to where the care is, whether it's the new St. Catharines cath lab or the Hamilton General cath lab, without a lot of hurdles and without a lot of hoops?

Back in the day when I started, you could spend 20 minutes on the phone calling specialists, and they would say, "Well, I'm not responsible for Haldimand," or "I'm not responsible for Port Colborne." That's gone now, so I think that's a way of equity.

Here in south Niagara, again, as the speaker alluded to, we've talked about trauma care. Is it realistic to set up a trauma hospital in south Niagara? Probably not, but with my colleagues, we've set up a system based on the system that Windsor uses to get critical trauma patients across the border into hospitals in our neighbouring cities. You've got great level 3 trauma across the river, and they were very happy to work with OHIP to get those patients seen and then get them repatriated.

So, equity comes in a lot of different ways. Again, in health links—here in LHIN 4, we're working with LHIN 3 and finding out some of the ways that they've smoothed out the equity between rural and urban, getting the IT and computer resources into providers' and doctors' offices that may not have the same rapid Internet connection as you've got with fibre optic in downtown Toronto.

I think collaboration is a big thing. At our LHIN, we have a primary care committee where family physician leaders, health link leads, all meet every other month with Dr. Everson and we talk about equity—"What are you doing that's getting patients the care that we're not doing here?"—and sharing best practices, sharing what works in one community and bringing it into the other. You're probably fortunate in having four LHINs; that's a lot of brainpower.

Mrs. Donna H. Cansfield: Trust me—

Dr. Jeff Remington: Well, it's a lot of people with great front-line ideas. I think the LHIN needs to be accountable and listen to those ideas.

The Chair (Mr. Ernie Hardeman): Thank you very much for that. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much, Dr. Remington. It was a great presentation. You mentioned, as part of it, that district health councils had been good grassroots organizations. I suspect they operated at a far lesser cost than LHINs operate at. Could you comment on, if you have an opinion on it, what the value-added is for LHINs vis-à-vis district health councils?

Dr. Jeff Remington: Well, I guess the way I understood district health councils is that they were strictly advisory. They did not have sort of the financial and fiscal responsibilities in handing out money and budgets that the current LHINs have. I think their strength was, as the previous speaker talked about, that they really did have a grassroots handle on what was going on in the community. I was brought in to deal with physician

human resources in 1996 because of the perception that Niagara was losing family doctors and we were getting family doctors. They asked me to get on the ground, find out what's going on, count doctors and then get back to them so that they could make recommendations to the ministry.

The problem is, that's a very long-reach process. The question always was whether or not the district health council recommendations actually made it into the minister's hands. We were lucky at the time in that we did have a cabinet minister locally that we could work through, but in the absence of that, I don't know whether those recommendations would have made it up the flagpole.

So I think the LHIN has a much larger role, which does make it a lot more expensive because they're actually looking at things like budgets. I would hope that the LHIN could take on a better role in terms of even looking at the efficiency and the effectiveness of the organization that it's handing money out to. Let's say we've got two diabetic education programs in the community. Find out which one is doing the better job. Will the LHIN get the power to actually remove the funding from one and give it to the agency that's actually doing the better job?

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The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Foster?

Ms. Cindy Forster: Forster.

The Chair (Mr. Ernie Hardeman): Forster. Oh, it's a bad day today.

Ms. Cindy Forster: Thank you, Ernie.

Thanks for being here, Dr. Remington. There seems to be a bit of a theme that I've heard today from a number of the presenters, that Niagara is kind of the poor sister in the scheme of funding. We heard a bit of that from you around the RFP process and the inability—because here in Niagara, we are made up of more small municipalities than large municipalities, such that we perhaps don't have the resources to be able to access some of those funds. Can you comment on what you hear in your neck of the woods?

Dr. Jeff Remington: Sure. Thank you. As I said before, it's hard being a group of small municipalities and being able to make the types of cases, either to the LHIN or to the ministry, to get funding for some essential programs.

Again, we've all heard about how there is conflict and there is infighting in Niagara. Twelve municipalities don't always speak with the same voice. I think in the past, our medical societies, the groups that represent physicians, have actually been very good at trying to speak with one voice, working with one voice. In the past, the majority of us supported one central hospital in Niagara, but that didn't happen.

I don't have easy answers. I think you're seeing more collaboration at our level. Certainly, the three health links are working together. We just had a meeting last week that Dr. Stobbe facilitated. Again, that brings in the Niag-

ara Health System and Ms. Boich; Ms. Riihimaki from the CCAC; your physician leaders and your nursing leaders. It's by communication that we'll start to work better together and work with a single voice.

But, certainly, having the resources to be able to make the type of proposals that a large university centre like St. Joseph's Hospital or McMaster University can put together—definitely, it's a challenge.

I can highly speak for the city of Port Colborne being a leader in health care—Joanne Ferraccioli is here with me today—and the fact that the city has enough foresight to actually put money into health care resources. Without her writing my proposals and speeches and making me look good, we wouldn't be anywhere.

Ms. Cindy Forster: Thanks very much.

The Chair (Mr. Ernie Hardeman): Thank you very much, and thank you, Ms. Forster. That concludes the presentation. Thank you very much for giving us your time.

NIAGARA HEALTH SYSTEM

The Chair (Mr. Ernie Hardeman): Our next presenter is the Niagara Health System: Marti Jurmain, vice-chair; Sue Matthews, acting chief executive officer; Kevin Smith, the CEO; Barry Wright, chair of the proposed board; and Brady Wood, chief communications officer.

It looks like there's no one at home minding the store.

We thank you all for coming in today to be part of this. We will have 15 minutes for the presentation. I would be willing to give you a few extra moments to fight it out as to who gets the time, but you do have 15 minutes. With that, you can use any or all of it in your presentation, and if there's time left, we will have questions.

Dr. Kevin Smith: Thank you, Mr. Chair. My name is Kevin Smith, and I'll undertake the presentation and we'll try to answer questions.

The Chair (Mr. Ernie Hardeman): Thank you very much.

Dr. Kevin Smith: I think you have before you—or I hope you have before you—our quick presentation. I won't dwell on all of the details within, in the interest of time, but as you know, the Niagara Health System is a large, complex, multi-site hospital system. There are a large number of in-patient and outpatient services across multiple sites.

In the last two years or so, the Niagara Health System has been under a supervision. I have been the supervisor and then, recently, the minister transferred the authority through the Lieutenant Governor back to the board. Ms. Jurmain and Mr. Wright are here on either side of me to keep me honest. We're very pleased to see local governance has returned to the Niagara Health System.

We have about 4,100 or 4,200 employees and over 620 physicians. It's a large, complex organization, as you've heard.

Let me perhaps dwell on a few important issues, rather than background issues, on LHIN relationships and

collaboration, and a few we'd like to start with in terms of the glass being very much half-full. We feel we've been very successful at the Niagara Health System, working together with the LHIN and partner hospitals to create a culture of collaboration amongst the many partners in health care. We see some results that we'll speak about in a moment that demonstrate that.

We've also enjoyed a strong working relationship with the LHIN and with their respective boards—Mr. Shea, I think, is here today, as well as Ms. Cripps—and they have been very fine colleagues for us to work with in this process, particularly during a period of supervision.

The LHIN has also, I believe, tried to strengthen relationships between provider groups. We've seen many, many fora bringing together clinician and non-clinical groups to look at how we, as a system, could function better, faster and cheaper in order to prevent loss of access for universal care. We also know that while the LHIN is not directly responsible, it's a very important player in capital renewal. We've seen unprecedented capital renewal in Ontario recently, I'm happy to say, with the minister's announcement recently of a large planning grant for continued development in the Niagara Health System.

In the next few slides in your package, titled "Integrations and Partnerships"—I won't go through them all—we tried to step back with a number of colleagues and just talk about: What has happened that's good in the LHINs? There are a large number of them available. I just want to particularly comment on a few related to Niagara. The cardiac care program, as you know, with the opening of the new St. Catharines site, brings a new tertiary service to Niagara and, as previous speakers discussed, prevents many Niagarans having to go to Hamilton or Toronto or other large centres in order to receive tertiary and sometimes quaternary care.

Similarly, we know that the fastest-growing group of illnesses include mental health and addictions. The development of mental health and addiction programs, with a recent infrastructure announcement, is also a very positive direction. We also, with the LHIN, have tried to attack some behind-the-veil activities, like our laboratory system, so that we can do a very good job of providing important services at a time when we were trying to get more and more money to the front line, so looking again at where we can not duplicate services, not duplicate infrastructure, and can build a world-class system has been something that the LHIN and the hospitals have worked very closely together on.

Last but certainly not least is the opening of the Walker cancer centre. As we know, cardiac and cancer are still the fastest-growing and most lethal diseases in our society. Niagara has now a state-of-the-art cancer centre, and that is coming up to speed and it's a very, very positive development.

The following few slides really talk to you about a number of other positives, as we see it: an important seniors' strategy; the importance of assisted living; talking more and more to keeping Ontarians where they wish

to be—in their homes; similarly, the importance of palliative care, end-of-life care and non-institutionally-based services; and the importance of bringing together providers across the continuum to ensure that for those who have needs, they are met most often at home or in a non-institutional setting, if possible.

We've also seen some very positive developments in small EDs partnering with larger EDs—we heard the previous speaker, Dr. Remington, speak about that—and see that as a very positive development as well. Similarly, health links and the infrastructure required for health links have really respected the view that we will not be looking for a solution for the province but working locally to look at individual solutions without trying to fit a square peg into a round hole. So far, our work with health links, I think, has proven very positive, both in a community-based setting and in a hospital-based setting.

On our page entitled “Opportunities,” let me talk about where evolution might be possible and where improvement still has great opportunity. We've taken the view that the LHIN is not, nor should it ever be, a static organization, nor should our own—that this is a point in time, and we've seen evolution, and the continued evolution of the LHIN in the following areas would be productive.

In ensuring better transitions across the care continuum, the LHINs and institutional partners, particularly primary care and hospital partners, have been very active in talking about how we break down walls between the often-siloed system of health services. We believe that there is a great deal more to do to integrate both within primary care and from primary care to institutional and community-based services. While the LHIN, I think, has started a very good track on this one, it may need some help and assistance and clarity from the ministry on how that goes and how quickly it might move.

We also believe that there could be improved consistency across LHINs in clarifying the authority and scope where there are divergent approaches. One of your committee members mentioned earlier that she has four LHINs in her riding. I work in two LHINs and I can sympathize that sometimes the variation is very healthy, like in health links, and sometimes it's very unhealthy, like where a policy, one would hope, would be applied in a very similar way. In a moment, we have a suggestion where we believe the ministry might be more helpful on that one for LHINs.

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We also believe that LHINs can be and are increasingly being data-driven and that data really is informing the discussion. That's a very positive development. The interface of LHINs with other provincial bodies like Health Quality Ontario and other quality bodies is also an equally important ingredient, so that we know the arms of government are aligned in a common agenda, as opposed to multiple agendas, which will put those on the front line of care provision in some degree of challenge in terms of many, many, many challenges and no great clarity as to which ones we're working on at one time.

We also know that the opportunity for LHINs to play an even larger role in helping to determine and then to disseminate best practice—the previous speaker talked about a couple of examples in terms of when one program is much more effective than the other. First, can we coach and mentor? In the absence of success, can we then consolidate? While LHINs have some opportunity to do that, I'd again go back and suggest that the Ministry of Health and Long-Term Care might work more closely with LHINs to better understand those opportunities and how quickly one can move within them.

We know the challenge for the LHIN is that, while it is planning, it also has to do funding, and recognize that with limited resources we won't make everyone happy, so brave decisions are important—brave decisions tempered by strong processes for engagement and demonstration of fairness and equity in process. That doesn't mean that we'll all like the outcome, nor should it. It does mean that fair process has been followed. Again, I believe that the ministry could help the LHIN in terms of defining what standard best practice might look like and what is acceptable.

In terms of policy and operations, increasingly I think the Hamilton Niagara Haldimand Brant LHIN is very much moving in this direction, but for all LHINs the opportunity for LHINs to focus on the “what” and the “why” and completely remove themselves from the “how” would be a great advantage. I want to compliment the local LHIN. Having worked in more than one, I see that as an objective they are taking seriously. That isn't necessarily the standard across the province and it really does need to be. If we're asking provider organizations to deliver, then we need to give them some autonomy in terms of how they deliver, not what they deliver and why they deliver and with what resources or outcomes they deliver.

We also know that the importance of aligning incentives is incredibly robust, but yet incomplete. Again, all of my comments and opportunities really refer mostly to the interface between the LHIN and the ministry and, increasingly, as we begin looking at how resources are flowing, the consolidation of those resources and ensuring that we are rewarding what we suggest we want. Unfortunately, we can all find examples where the right and the left hand aren't perfectly aligned, and we believe that that process can be improved, particularly between the ministry, the transfer payment agencies and the LHIN.

The budgeting process: I think you'll hear from all transfer payment agencies that it would be ideal to have a more robust timeline that is really predictable. All too often—I believe this applies to the LHIN as well as to the transfer payment agencies—the annual in-year spend or budget isn't as clear as early as we'd like it to be. So when we need to make changes to services, it may or may not be easy to do so with in-year. An earlier budgeting cycle with great clarity about the full envelope of resources would be a great desire.

Our final thoughts on the last page of our package: As we say, the glass is very much half full. We've seen en-

hanced collaboration and collegiality, particularly in this LHIN. We've seen support for all health facilities, not only hospitals, in capital renewal and community engagement. We've seen significant, concrete outcomes in terms of programmatic integration; a number of those are available. We talked about a number of the clinical ones earlier—cancer, cardiac, mental health, laboratory services and more to come.

We also would like to recognize the importance of streamlining our system so that the patient really is first, and that a great patient experience, which is this LHIN's objective, is fulfilled. We would complement the great patient experience with a great quality of work life. We know we don't have satisfied patients if we don't have satisfied providers. Again, I would say the LHIN has been very receptive to working with us in that regard.

We also believe that we want to encourage the LHIN's continued evaluation of outcome and engagement, perhaps with the academic health science centre; all LHINs are associated with one. Are the relationships between the academic health science centres and the host LHIN as robust as they could be? We've heard a number of discussions here today with regard to the Niagara campus of McMaster—perhaps another opportunity going forward.

We recognize that form and function must be aligned. Whatever the outcome of form and function, a number of the processes and alignments we've talked about today we believe should be reflected in the evolving LHIN system.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have three minutes left, so we will send it over to the official opposition.

Mrs. Christine Elliott: Thank you. Thank you very much, Dr. Smith, for your presentation. It was very helpful.

I just wanted to highlight one of the items that you mentioned under opportunities, where you said that the Ministry of Health should be clearer to the LHINs where they have autonomy and where they do not. I would say that's probably the single biggest issue of frustration that's raised to us by constituents: that they go to the LHIN and they're told, "You need to go to the ministry," and vice versa. Could you suggest ways that we could minimize that and what we should do about that?

Dr. Kevin Smith: Yes. I think that one of the models is to really begin talking at a policy level about what LHINs can do best and where we'd like to see variability in the 14 regions, or however many there end up being. That might be health links and clinical delivery models; it might be in recognizing how service is delivered. What I don't think we want to see is a different application of the funding formula.

And are there some core programs—for example, emergency services comes to mind because of the sensitivity of it—where we are extremely clear about what should be available and what will be delivered? Then, laterally, here's where great flexibility occurs. So I think for us, the model would be tremendously helpful if we could say—the LHIN folks can talk about this much better than I—"Here is where you have some autonomy for movement." It might be in how you deliver clinical care; it might be in a hub-and-spoke model versus a more regional model. But the delivery, the measurements, the outcomes that we've agreed upon shouldn't be different—and the mechanism of funding so that LHIN A and LHIN B can actually rationally say to residents, "You don't pay a differential tax rate; you can expect the same basis of a system."

The Chair (Mr. Ernie Hardeman): You have another half a minute.

Mrs. Christine Elliott: And maybe perhaps, as a physician, if you could comment on the fact that primary care is not currently included and how you think it could be included. What would be the mechanism for doing that?

Dr. Kevin Smith: I should clarify: In the Dark Ages, I was a medical educator; I now am but a mere administrator. So I just go back and let my clinical front-line colleagues talk about the specifics.

But I think when we look at the potential lack of integration around some of the funding models in primary care and institutional care, and the lack of a consistent scorecard that spans the continuum—many silos are working very hard to get really good data and really good scorecards. What we haven't yet created is, what's the scorecard across the continuum? We could talk about diabetes from primary care through to speciality services, if required, or, similarly, other services that require a broader continuum of care than one provider group. I think the scorecard is the place to go, and clearly evidence of best practice and opportunities for improvement with, I think, Health Quality Ontario being the coach and our LHINs and ministry being the critic, is probably a very robust model.

Mrs. Christine Elliott: Thank you very much.

The Chair (Mr. Ernie Hardeman): That concludes the time, and we thank you for being here today. I'm sure it will be very helpful in the committee's review.

Dr. Kevin Smith: Thank you very much.

The Chair (Mr. Ernie Hardeman): That also concludes the presentations today. There being no further business of the committee, we will adjourn, and we will meet tomorrow morning in the great city of Hamilton.

The committee adjourned at 1351.

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Official Report of Debates (Hansard)

Tuesday 28 January 2014

Journal des débats (Hansard)

Mardi 28 janvier 2014

Standing Committee on Social Policy

Local Health System
Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur
l'intégration du système
de santé local



Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 28 January 2014

Mardi 28 janvier 2014

The committee met at 0900 in the Centre Ballroom, Sheraton Hamilton Hotel, Hamilton.

LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Good morning. We'll call the Standing Committee on Social Policy to order. We're here at the great Sheraton hotel in Hamilton to review the Local Health System Integration Act and the regulations made under it as provided for in section 39 of that act. We're doing the public consultations on that, and we welcome all of the people in the audience.

HAMILTON NIAGARA
HALDIMAND BRANT COMMUNITY CARE
ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Our first delegation this morning is from the Hamilton Niagara Haldimand Brant Community Care Access Centre: Melody Miles.

Mr. Mike Colle: Point of order.

The Chair (Mr. Ernie Hardeman): Yes?

Mr. Mike Colle: Mr. Chairman, I just thought it would be helpful for me, and maybe other members of the committee, if we could have some employment data as relates to the LHIN areas to see how many people actually work in the health care fields, like in the hospitals and in the CCACs, so just the number of people employed in health care—publicly funded, in other words—for this LHIN here.

It doesn't have to be done today, but as we go, I'd like to have this background material of how many jobs we're talking about in these LHIN areas.

The Chair (Mr. Ernie Hardeman): Okay. I thank you very much, and the staff will take that into consideration and prepare that, but I guess it doesn't relate to the public presentations today. We are here today to hear from the public, not to talk to the public.

Mr. Mike Colle: No, no. But I have the right to ask for research material.

The Chair (Mr. Ernie Hardeman): I'm not questioning your right at all. I'm just saying that we will deal with that, but we have to hear the public now.

Mr. Mike Colle: Okay. I'd like to get that research material, so I'm going to give this to the researcher.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have Melody Miles, chief executive officer, and Dilys Haughton, director of client services operations and professional practice lead. Welcome, ladies. I'm happy to have you here this morning. You will have 15 minutes to make your presentation. You can use all or any of that. If there's time left, if it's less than four minutes, we will have just one caucus ask questions or make statements. If there's more than four minutes left, we will rotate it and divide the time evenly for everyone here. With that, welcome, and the floor is yours.

Ms. Melody Miles: Thank you. Good morning, Chair and honourable members of the committee. My name is Melody Miles, and I'm the CEO of the Hamilton Niagara Haldimand Brant Community Care Access Centre. I am a nurse by profession and have held executive leadership positions with a variety of community-based health care organizations in the home care and public health sectors.

With me today is Dilys Haughton, director of client services operations and professional practice lead for the CCAC. Dilys is a nurse practitioner and is the clinical lead for a number of our programs. She also has an active caseload and provides care to some of our most complex patients.

We are very pleased to have this opportunity to speak with you this morning. We work closely with the LHIN and others to support the delivery of care in this region, which is home to more than 1.4 million people.

We believe this review process provides an important opportunity to gather feedback from local stakeholders. The Ontario Association of Community Care Access Centres, our provincial association, will be providing a written submission with a detailed series of recommendations from our sector. Rather than repeat those, we will be using our time today to provide the local perspective and focus on the following: how the legislation sets a framework for local health system planning, funding and accountability. We'll profile some recommendations for consideration, provide an example of the importance of the role of the LHIN in our system and, finally, we'll share a patient story to illustrate the impact, at the individual or patient level, of the LHIN's leadership and investment.

On balance, we believe that LHSIA is a fundamentally sound piece of legislation that sets out a solid principle-based framework for local health system planning, funding and accountability. Regardless of the way the

health system is structured, the functions of LHINs—planning, funding and accountability—must be carried out. Given the size, complexity and diversity of Ontario's population and geography, we believe these functions are best carried out at a regional level. Ultimately, it is the relationships that are key to making the system work for patients.

LHINs carry out local system level planning and funding, and are accountable for health system performance in their regions. They work with health care providers to organize, plan and deliver health care services to meet the needs of the populations. Although we share the same geographic boundaries as the LHIN, the work that the CCAC does is different.

CCACs work with individuals to help them get the care they need when and where they need it. CCAC care coordinators are regulated health professionals: nurses, social workers, physiotherapists and others. They work with patients and their families to understand their care needs and goals, and to develop individualized care plans and link them with services. They help people to remain at home, avoid hospital admission, access support upon discharge from hospital and explore long-term-care options.

Last year, HNHB CCAC provided care to more than 75,000 individuals across our region. Each month, the CCAC helps more than 3,600 hospital patients transition home with CCAC services, as well as admits 1,900 patients directly from community. We also help 250 individuals transition to long-term care.

The patients we serve vary in age and complexity of need. Last year, we served half of all seniors in this region aged 85 and older. Some 12% of our patients were under the age of 20, and nearly 30% were between the ages of 20 and 64.

CCAC care coordinators lead the delivery of home care services in collaboration with our service providers and system partners. We are in every hospital, including every emergency department. We work with every school and every long-term-care home, and are sited with many primary care providers in the region.

Care coordinators meet with people in hospitals and in their homes, to understand and support their care needs. This may include the provision of nursing, personal support or therapies, and access to community services such as adult day programs.

The package we have shared with you includes a page highlighting our linkages with patients and partners.

We know the importance of working hand in hand with primary care providers. We are full partners in the development of all 11 health links in our region. We're very proud that, for many years, the HNHB CCAC and its predecessors have had care coordinators attached to and sited with primary care providers. Currently, we have 77 care coordinators with formal attachments to 258 family physicians across our region.

We recommend that LHINs be enabled to continue to work with a range of system providers, including primary care, public health and emergency medical services.

These partnerships are critical to building a system that supports healthy aging and chronic disease prevention and management.

Some of our patients living at home have very advanced care needs, and the interventions and supports they need are more complex than ever before. This trend underscores the need for clinical care and expert coordination of health care services in our communities. It also speaks to the reality that all of us, no matter how complicated our care needs are, would prefer to be in the comfort of our own home with supports, rather than in any other setting.

Down the street from here is Hamilton Place. It's one of the region's main concert venues. You've likely heard the saying that "No one can whistle a symphony. It takes a whole orchestra to play it." That was Halford Luccock.

The LHIN brings partners together and leverages their strengths and resources to support coordinated, effective and efficient services. In a sense, it is the orchestra conductor of the health care system symphony. The legislation speaks to this role and, through the LHIN's Integrated Health Service Plan, with input from the CCAC and others, sets directions and priorities for the region.

One of the key system imperatives is to enhance coordination and transitions of care. In our region, the LHIN has convened a system flow steering committee, which is co-chaired by leaders from Hamilton Health Sciences and the CCAC and includes representation from long-term care, community support services, and other partners. It has supported the development of innovative models of care, including assisted-living hubs and a rapid response transition team; and has enabled development of a secure web portal, delivering an integrated electronic health record, linking records for primary, acute and home care, and it's called ClinicalConnect.

Together, we've made some remarkable achievements, including a significant decrease in the number of alternate-level-of-care days. In 2012-13, there were 54,000 fewer ALC days than there were two years earlier. The bed days that were saved are the equivalent of a 149-bed hospital, at 100% occupancy, being made available to patients in our system each and every day.

The rapid response transition team, a precursor to the rapid response nursing program that is now established in all CCACs across the province, is an example of how the planning and funding role of a LHIN enables improved coordination of local system resources and improved patient outcomes.

We understand that presenting numbers provides only part of the picture, so Dilys is going to share a story about one of our patients who experienced this type of care.

0910

Ms. Dilys Houghton: Good morning. As Melody indicated, our patients have benefited from having the LHIN as the orchestra conductor. The LHIN has brought partners together and has enabled us to leverage our expertise and assets to improve patient care.

As background, a couple of years ago, the LHIN approached several partners, including the CCAC, to develop innovative programs that would support patients at transition points and continue to improve system flow. Following research and consultation, we proposed a program for some of our most complex patients that would provide a more expanded home care team at the point of transition to include rapid response nurses, nurse practitioners and pharmacists; access to in-home laboratory tests; bridge system gaps by providing primary care in the short term and assisting connection to primary care in the longer term; supporting medication reconciliation and management; and providing health teaching.

The LHIN identified that one of our hospital partners, Hamilton Health Sciences, was also looking at this issue from the hospital perspective and brought us together to leverage our shared expertise and resources to support this specific group of patients. I'd like to share a story of one of those patients. Let's call her Marie.

Marie was a 75-year-old woman living in a retirement home. She had just come home from the hospital and had been identified in the hospital as a patient requiring additional support. Her acute care needs had been met but there were some concerns about her ongoing health and ability to manage independently. She had been in and out of hospital many, many times over the last year. She had several chronic conditions, including emphysema, heart failure and diabetes, and from her diabetes, she had kidney and nerve pain complications. She also had a number of other health conditions, including hypothyroidism, hypertension, osteoporosis and osteoarthritis, degenerative disc disease, gastroesophageal reflux disease, diverticulosis, venous stasis ulcers in her leg and sleep apnea. Marie is similar to many other complex patients that we see in our program, and she is among some of the most complex patients in the health care system.

Marie had difficulty getting in and out of bed due to being deconditioned following her hospital stay. She was short of breath and using oxygen. She was gaining weight and her diabetes was not under control. She also reported very severe pain in her legs, the worst possible imaginable, at 10 out of 10. Her most important wish, however, was to stay out of hospital.

The CCAC's nurse practitioner began to work with Marie to address her care needs. Leg pain due to diabetic neuropathy was Marie's most pressing issue. The nurse practitioner worked with our pharmacist and her family doctor to add medication to help with this. Within only one week, Marie was already starting to feel better and her pain was reduced to seven out of 10.

We worked with her respirologist and retirement home staff to better recognize and manage her COPD flare-ups. We involved physiotherapy and occupational therapy to help her manage more independently. We involved a dietitian to work with Marie and to build capacity in the retirement home staff to address her nutritional needs and get her diabetes under better control. As the nurse practitioner got to know her, she identified depression as an issue and started medication.

The outcomes were remarkable. Within only one month, Marie's self-reported pain was only two out of 10. She was more mobile, losing weight, and her diabetes was under better control. As Marie said, "I haven't felt this good in 25 years." I am also pleased to report that we helped Marie stay out of hospital, with not one hospital admission in the year following our involvement.

This story highlights how, through the provision of quality, patient-centred care, coordination between providers and increasing provider capacity, we are improving patient outcomes, reducing costs by using health care resources appropriately and ultimately improving the patient's care experience.

In your package, you will find a few patient journey stories, including one entitled "Jack's Journey," which is about another patient, similar to Marie.

Ms. Melody Miles: Dilys has told you the story of just one patient we have cared for with innovation and support from the LHIN.

Last year, we provided care to one out of every 18 people in this region. We don't do this alone. We do this in concert with our many system partners, including service providers, hospitals, primary care providers, emergency medical services, long-term care, school boards, informal caregivers and others. Many of these partnerships come about as a result of building relationships over time and working together.

We recognize that having these types of integrated programs will support patients and caregivers. At the same time, we know that we need to better understand and plan for future system capacity. Our provincial association has launched a series of discussion papers which expand on some of these key issues.

I thank you for leading this important dialogue. We know the system and services will need to continue to evolve, grow and adapt. We are particularly grateful for the recent focus and importance being given to home and community care. Going forward, we will need to continue to have solid leadership and system planning to fully utilize the capacity of our human technology and other resources as we provide preventive, healing and palliative care for the residents of our region.

I thank you for your time today. We would be pleased to respond to any questions you may have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It was very well done. You've timed it within seconds of 15 minutes. We'll take it into consideration as we move forward with this review.

ST. JOSEPH'S HEALTH SYSTEM

The Chair (Mr. Ernie Hardeman): Our next presenter is St. Joseph's Health System: Kevin Smith, president and chief executive officer; David Higgins, president of St. Joseph's Healthcare Hamilton; and Tony Valeri, director of St. Joseph's Health System. Kevin, you look somewhat familiar.

Dr. Kevin Smith: It's true, Mr. Chair. I'm not stalking you.

The Chair (Mr. Ernie Hardeman): The instructions for your presentation today will be the same as the instructions were yesterday. We welcome you back, and the floor is yours.

Dr. Kevin Smith: We thought we'd come back till we get it right, Mr. Chair.

Dr. Higgins and I are pleased to be with you here today. Obviously, we're going to talk a little bit about St. Joseph's Health System as it plays within the LHIN.

St. Joe's is one of Canada's largest and most comprehensive health care organizations and, perhaps most importantly, the first in Canada of the academic health science centres to consolidate across multiple LHINs and all of the continuum of care, from primary care through to palliative care, including academic teaching hospitals.

Our experience with the LHIN in developing that model has been nothing short of remarkable. The local leadership of the LHIN has been a key partner in allowing the management of the continuum to evolve and, increasingly, for a focus on primary care and specialty services, home care services and community-based services, as well as social services to be well integrated in the complex needs of complex patients.

Clear strengths of this LHIN:

- a very well-articulated patient-first focus;
- significant support and respect for the contributions of local provider organizations and local governance;
- creating a culture of co-operation and team-building; and
- support for enhancement to community-based programs through the Ministry of Health and Long-Term Care, community and social services and numerous philanthropic organizations.

I think the other key strength of the Hamilton Niagara Haldimand Brant LHIN is engaging local physician, clinician and administrative leadership in bringing solutions to complex problems. That includes those who do the work on the front lines being very engaged in the solutions.

I've mentioned our integrated continuum-of-care project, which I won't dwell on here today. It's in your package. It has been a novel journey for us, moving from the mindset of a hospital to the mindset of a systems manager across the continuum of care, working with our funding partners, and community and social services partners as well. We'd be happy to expand on that should there be interest later.

I think the other potential opportunities for the LHIN, which was one of your key questions for today, are the engagement of the gatekeepers in primary care, particularly primary care physicians, nurse practitioners, community health centres and others—a key and important ingredient going forward; a greater emphasis that continues the development of partnerships and continuity, particularly focused on vulnerable populations, those who are the highest consumers of care and often those who are most economically and, at times, genetically disadvantaged. Health links is a very good start to this program.

The LHIN has advanced the model of robust business planning so that economics and clinical quality are well matched and the importance of data and data application in decision-making can continue to be refined.

0920

In closing, our focus really, increasingly, will be on the model of care that allows us to procure health care and the model of care that allows us to deliver health care. By creating a strong relationship between those who purchase the service and those who provide it, respecting the respective roles, and also recognizing that the funder—it's very legitimate and important to focus on "what," and the provider must be permitted to focus on "how."

Perhaps I'll stop there, in the interests of time for questions and dialogue.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will start the questions. We have about 11 minutes left, so with that, we'll start with the third party.

Miss Monique Taylor: Hi. Nice to see you again.

Dr. Kevin Smith: Nice to see you again.

Miss Monique Taylor: Thank you so much for wanting to participate today and being present here, and for putting together a summary of what's happening with St. Joseph's Healthcare. My question would just be about how we're finding our wait times coming within our region.

Dr. Kevin Smith: Yes, we are making some significant progress. We have some significant areas for improvement to continue. The region has done a remarkable job in improving access to diagnostic services.

Similarly, the LHIN, working with the ministry, has freed up some resources. You may have seen last week in some media a focus on cataract care, that there was a gap, and the LHIN and the ministry did a very, very good job, I think, of coming back on that.

That having been said, a lot of work is being done on wait times that also allows us to get better information. I'll just give you an example that Dr. Higgins has been working on: When is the appropriate time for an intervention with a procedure like a cataract? So, when is the cataract appropriately ripe? It's very difficult to evaluate across the province, so I think our next steps in wait-times management will be better data, better criteria and better models of clinical judgment in comparison. I'll ask Dr. Higgins if he wants to add to that.

Dr. David Higgins: Thanks. Yes, I agree. I think that the challenge we're looking at in cataracts is an example of how do you create a more standardized and effective manner for assessment of patients, because not all patients are the same; we know that. A good example we sort of use is if I was a marksman, my objective feat for having surgery might be different from maybe Dave Higgins who's simply a hospital executive. So I think that we need to balance out the patient's needs versus the wait time and understand the acuity and intensity. That's one of the things we want to work on. What the LHIN has helped us do is focus on a LHIN-wide focus on understanding the assessment processes more effectively.

Going forward, then, with the LHINs who [*inaudible*] plan driving on quality, patient experience and quality is going to be a key focus on how to manage that in the context of wait times.

Dr. Kevin Smith: Ontario has gone from worst to first in wait-times management.

Miss Monique Taylor: Worst to first?

Interjection: Yes.

Miss Monique Taylor: Where are we sitting with cataract surgeries? Because that's a really good point that's been raised. I know myself, in my office, hearing from people who are saying that they're waiting for such a long time just to get one done, and then having to wait the exact same amount of time to get the other one done. So it's become a serious issue.

Dr. David Higgins: We agree with that, and I think that we need to have a more clear understanding of those factors within our region, and also, then, to ensure there's fairness and equity across the region. Our minister has very clearly said, "Patients need to have choice." And where patients can be offered surgery in a more rapid fashion, we want to help engage that, too. It's complicated, but I do think a more transparent approach to this from all—from the patient's perspective, the provider's perspective—will be an important first start, and then driving to quality as well to ensure equity, that we manage resources appropriately.

Miss Monique Taylor: Thank you.

The Chair (Mr. Ernie Hardeman): One more minute.

Miss Monique Taylor: Community urgent care centres: Where are we sitting on that? There's large growth in my riding, specifically in the Mountain, which covers Glanbrook, Ancaster, all of that area which I believe does not have enough urgent care. What are your thoughts on that?

Dr. Kevin Smith: It's a great discussion, and the number of urgent cares, as you know, is a rapid debate around the province of Ontario. I think the future is more about 24-hour access to primary care, with appropriate primary care coverage, and then rapid transport for those truly urgent or emergent things.

Again, I think one of the opportunities for the evolution of the LHIN is getting a little more involved in and being given the authority to do so in primary care planning. I don't believe we're going to see more free-standing urgent care centres as the solution. When we look at the number of providers available, we may be better positioned to look at how we do after-hours care with primary care providers.

Miss Monique Taylor: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We now will go to the government. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair. Dr. Smith, I was interested in your comment that St. Joseph's, as an academic health science centre, has provided some leadership and coordination across several LHINs. Many of us actually represent ridings in the GTA, where we have a number of different LHINs, and I think that—

again, on behalf of our constituents—we have noticed that there is tremendous disparity in some of the services provided between the LHINs.

How have you at St. Joseph's been able to use your academic health science centre to reach out or to coordinate or to suggest best practice? Can you sort of fill us in on how you played that role?

Dr. Kevin Smith: Sure. The first model, I would say, is that we've tried to focus on where the burden of illness exists: Is there a real need and a problem? Secondly, what's the data and what's the information or published literature that suggests improvement is possible? Lastly, and most importantly, is talking to those who deliver the work directly and those who receive the service about what "better" might look like.

I think we've done a reasonable job within the two LHINs that we work in. I would say that the opportunity to spark innovation across LHINs is still an opportunity to be further exploited in the future.

Again, you've heard this from me recently: Where the LHINs have autonomy or greater autonomy, and where they should have less autonomy, I think, is something that the Ministry of Health and Long-Term Care and the government of Ontario can help define. At the moment, I think that's still a little broader, and perhaps what you're experiencing across jurisdictions is as a result of that.

It is a fine balance. We want things like health links to be flexible and responsive to the population but, equally, we want to be able to say that Ontarians have similar access to appropriate services. I think that engaging the LHINs in a discussion about where autonomy is appropriate, and perhaps where less autonomy would be better at a systemic level—and the ministry being clear with that—would be helpful.

Ms. Helena Jaczek: Just as a follow-up, we've heard a number of suggestions that physicians should be somehow brought into the LHIN structure. We know community health centres are already part of that. Do you have any practical suggestions or some feelings as to whether, in a structural way, we should incorporate physicians or physician groups in some way?

Dr. Kevin Smith: Sure. Let me start, and then a practising respirologist can disagree with me. The focus, I think, increasingly has to be about integration, and it's folly to suggest that you can talk about health service delivery and leave physicians, the principal providers of direct medical services, within their scope of practice.

I think it's increasingly about how you engage physicians. I would say that hospital-based physicians are more engaged in this process by the nature of their work, because the hospital is so engaged with the LHIN process. My belief is that it is somehow better integrating primary care, and being perhaps clearer with the LHINs and with the primary care community as to what the relationship might be, should be and could be.

While I recognize that the Ontario Medical Association is the only negotiator on behalf of physicians in Ontario for compensation issues, I think the LHIN can play a very significant role in the design-and-delivery

model—again, the “what”—and then challenge the field back with the “how.”

Lastly, I would say, do we have the right fora where we’re actually getting the continuum of care at the table to talk about a system-wide solution, as opposed to, “We’re going to solve a cataract problem”—which I’m not diminishing, but a cataract problem in isolation with a patient who’s also diabetic—as Ms. Miles and her colleagues were talking about, with the very complicated Marie—I think that’s a place where we need to engage physicians much more actively and be clearer about what LHINs’ roles, responsibilities and accountabilities are with physicians.

David, do you—

Dr. David Higgins: I think the community is key to the future of the health care system, and primary care is a huge part of that. It’s fundamentally and critically important that that becomes part of the conversation and part of the overall structures.

The Chair (Mr. Ernie Hardeman): Well, thank you very much. Ms. McKenna?

Mrs. Jane McKenna: Thank you so much, Dr. Smith. It’s a pleasure to see you again today. I think my first question is—I see the relationship that you have with my CEO, Donna Cripps, is working and is great. I know that with my office, as MPP, she has been a phenomenal support for us.

Dr. Kevin Smith: Absolutely.

Mrs. Jane McKenna: But all those resources that you have here—I think we found, numerous times, that all 14 don’t actually flow together when there’s information given to each other, and there is a massive disconnect between one and the other. How could we solve that so one hand’s talking to the other, instead of each one being in their silo?

0930

Dr. Kevin Smith: I’ll maybe go on a theme—the data theme—yet again. I’m hoping that we’ll see—and I know that Hamilton Niagara Haldimand Brant and other LHINs are working towards a systemic scorecard. We’ve done a lot of work, particularly in hospital-based or surgical procedures, which are easy to measure: “Did I or didn’t I get what I said you’d get on time?” But I think the investment in a system-wide scorecard by LHIN, with targets and improvement statistics being very, very clear—I think, then, somehow engaging the Ministry of Health and its various arms, like Health Quality Ontario, for the mechanism of standardization helps. What we learned in wait times 1 and 2 was very clear: that data, money and embarrassment are very powerful tools for change.

Mrs. Jane McKenna: Yes. I do recognize, though—it is the Minister of Health, right? If you have leadership in that area, it does filter down to the rest, right? Because clearly there is, in the meetings that we’ve had here, a disconnect right from one to the next. So that’s great, because we’re here to fix those situations ourselves with the information that you give us.

The next question I have is, you measure your success by the success of your patients. So how do you measure

those outcomes? I realize that Ms. Miles was here giving us some of those stories, but those are your job description of things that you should be doing on a daily basis. As an MPP—I won’t speak for anybody else—we have a lot of people who come in who are not, clearly, getting those services at all. So how do you measure the success of the patient so we can actually make the system better?

Dr. Kevin Smith: As you know, it’s an incredibly complex issue, and you’re measuring want versus need, at times. We know that in many rationalizations of health services, what people want may not be well aligned with the best evidence. We know that when we try to consolidate services and when consolidation of services increases quality in certain domains, we still don’t necessarily have communities say, “Great. Why don’t you take that away from me and move it over here?” even though the evidence, the data, is extremely clear. So I think we have to continue to come back and talk about how we communicate with people with very complex clinical evidence.

I think the latter part is engaging the public in what the appropriate standard of care is and increasingly being clear about what we are able to afford to do with the limited resources we have, and perhaps what we’re not able to do. I know that’s a very, very difficult task for all of you who have elected positions to represent the people of Ontario, but I think, in a rational system, we’ll increasingly be talking about what our priorities are and what is, in our language, a strategic plan.

Sadly, when limited resources exist, we also have to make some decisions about what we won’t do, or, perhaps, more impressively, what we’ll do in a less costly way, often by people who are less costly.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. I do want to point out that I mentioned that we saw you yesterday.

Dr. Kevin Smith: Yes.

The Chair (Mr. Ernie Hardeman): It was representing a different group of people.

Dr. Kevin Smith: It was. Yes.

The Chair (Mr. Ernie Hardeman): So we weren’t hearing the same presentation.

Dr. Kevin Smith: No. It was Niagara yesterday and Hamilton today.

The Chair (Mr. Ernie Hardeman): Thank you very much.

BOARD OF NORTH HAMILTON COMMUNITY HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): Our next presentation is the board of the North Hamilton Community Health Centre: Elizabeth Bearer, chief executive officer, and Kim Rynn, board chair.

Thank you for being here today. We very much appreciate you taking the time. As with other delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for the presentation. If there’s any time left over, if it’s less than four minutes, it will go

to one caucus. If it's more than four minutes, we will divide it evenly among all three caucuses to give everybody an opportunity. With that, the floor is yours. Thank you very much.

Ms. Kimberley Rynn: Thank you. Good morning, Chair and honourable members of the Standing Committee on Social Policy. My name is Kimberley Rynn. I am the board chair of North Hamilton Community Health Centre. With me is Elizabeth Beader, our CEO. We're very pleased to make this submission to your committee on LHSIA.

I want to start by giving a little bit of context about North Hamilton. It's an organization where I've had the good fortune of having a role as a volunteer governor for over 13 years, so I have a lot of passion for the organization.

North Hamilton Community Health Centre is one of seven CHCs across our LHIN, Hamilton Niagara Haldimand Brant. Our vision is: no obstacles to health, and our mission is: enabling health through healing, hope and wellness.

CHCs are primary health care organizations that outreach to individuals and communities who have barriers to the health care system. CHCs are the only primary care model accountable to the LHIN.

The overall aim of the Hamilton Niagara Haldimand Brant LHIN is to dramatically improve the patient experience through quality, integration and value. The HNHB LHIN's three key strategic directions flowing from this aim are, first off, to dramatically improve patient experience by embedding a culture of quality throughout the system; secondly, to dramatically improve the patient experience by integrating service delivery; and thirdly, to dramatically improve the patient experience by evolving the role of the LHIN to become health system commissioners.

It is the intent of our submission to take advantage of the LHIN's full potential in enabling improved health outcomes at the best possible cost. With that, I want to hand it over to Elizabeth, who is going to review our submission.

Ms. Elizabeth Beader: North Hamilton Community Health Centre has experienced good results in the relationship between a regional funder—our LHIN—and our local community needs. The regional body understands our regional perspective, our unique realities and the distinct attributes of our communities in which our LHIN is situated. The local realities of quality, performance, funding and evaluation are well understood at the local level.

One of our key issues that we wanted to bring forward around the legislation is that the LHINs do not have jurisdiction over other models of primary care under the current legislation. CHCs provide excellent primary health care services to 2% of Ontarians. It is acknowledged—and we've heard from the previous presentations—how primary health care is the foundation for the health system and therefore essential to reform.

It's critical that the entire primary health care system fall under the accountability of the LHIN as an enabler to

a high-performing health system. This means that all models of primary health care, including family health teams, family health groups, solo practitioners and all other models currently funded by the Ontario Ministry of Health and Long-Term Care must be accountable to the LHIN for quality, performance, funding and evaluation.

Just to highlight that, the LHIN's ability to achieve results is curtailed due to scope limitation in that they do not have jurisdiction over other primary health care models.

The second point that we wanted to make was that the act should be enhanced to support illness prevention and wellness initiatives to prevent more and treat less. The act should expand to include objectives related to health promotion and illness prevention. The act should expand to include a strong focus on the broad determinants of health. Performance indicators related to health promotion and illness prevention should be developed, and all primary care models and other health service providers, along with the LHIN, held accountable for those results.

The third point that we wanted to make was that a balance between local approaches and standards across LHINs should be evaluated. The regional body, as said before, understands the regional perspective, unique realities and distinct attributes of our communities. Solutions and funding those solutions, we acknowledge, are regionally distinct. However, there are certain standards, such as percentage increases to budgets, rules regarding accessing surplus and commitments to keeping surpluses within the community health sector, to name a few, that need to be standardized across all LHINs.

Finally, a commitment to health equity is crucial in dramatically improving the patient experience through quality, integration and value, ensuring that there are no obstacles to health. We are recommending that all LHINs have a health equity indicator or target included in all of the SAAs as a starting point to begin understanding the local issues related to reducing health inequities. We are recommending that the health equity impact assessment tool that has been developed by the Ministry of Health and Long-Term Care be used in regional planning and province-wide initiatives.

We're ready for questions, if you have any.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have about nine and a half minutes left, so we'll start with the government side. Mr. Colle.

Mr. Mike Colle: First of all, I want to commend you for volunteering for 13 years to serve on the board of your local community care centre. Thank you very much for that volunteer service. I know that there are a lot of volunteers who work in the community health centres that make it so good. I'm a great fan of the community health centres. I have two in my riding, and I think they are the best kept secret in health care. The newspapers never talk about them; the media is not interested.

0940

Anyway, I just wanted to ask you: The one key point I think you made is that the community health centres are

under the LHIN. Then you provide primary care with your nurse practitioners and your doctors, right? Yet, you mentioned that the rest of primary care providers are not under LHIN jurisdiction. Are you inferring or are you trying to state—and I'm not trying to be confrontational—that maybe more primary care providers should be under the LHIN? Would that help you and others in getting access to better service if LHINs had more say in primary health care delivery?

Ms. Elizabeth Bader: I think what we're saying is that our relationship with the LHIN and our accountability to the LHIN has proven that the solutions that are system-wide and include primary health care can happen in partnership. But when you have a key group of individuals—who I would say are the gatekeepers to the system—not under the LHINs, the ability—

Mr. Mike Colle: You're saying the doctors, right?

Ms. Elizabeth Bader: The physicians, yes, in different funding models are not accountable to the LHIN for volumes, for initiatives across the sector. I think that the LHIN has done a phenomenal job in pulling that primary care group in to have conversation, to be part of the health links, to be part of those initiatives. But they are not accountable to the LHIN, and we believe that the entire primary care arena needs to be under the LHIN's purview so that the creative and innovative solutions that the Hamilton-Niagara-Haldimand-Brant community has developed in partnership with the LHIN can occur and have some accountability around it.

Mr. Mike Colle: Yes, and you mentioned the importance also of looking at the broad determinants of health, in other words, poverty, lack of housing. Could you give me a specific example of how, if we spend more time looking at that and their relationship to health that that would help deliver better health care and better outcomes?

Ms. Elizabeth Bader: There's a lot of evidence that shows that if somebody is homeless or under-housed or is hungry or is unemployed that they are going to be sicker than somebody who isn't hungry or does have a home or does have friends or does have employment. There is all kinds of research out there that shows that. What a community health centre does is try to understand those broad determinants of health in developing a care plan for an individual and then using that full understanding of the client in developing what will make that individual healthier.

It might mean that we need to have a client advocate that links that individual who may have extremely complex health issues, like diabetes with a comorbidity of heart disease and may even have asthma, and understand that they're living in either substandard conditions or living on somebody's couch with carpet, so their breathing is going to be an issue with their asthma. They're not able to follow up with their prescriptions—

The Chair (Mr. Ernie Hardeman): Okay.

Ms. Elizabeth Bader: Okay, sorry. I'm going on.

The Chair (Mr. Ernie Hardeman): Thank you. Mrs. Elliott.

Mrs. Christine Elliott: Good morning. Thank you very much for presenting to the committee today. I'm also a big fan of community health centres, and I think that your efforts do go unnoticed and they shouldn't be. I think it's a great service you provide to many marginalized people in our communities. I think your presentation really reflects that unique perspective that you have, and has raised a couple of questions. One of the questions I have relates to evolving the role of the LHINs to becoming health system commissioners. I'm wondering if you could expand on that a little bit about what you mean by an enhanced role of the LHIN?

Ms. Elizabeth Bader: We've put that in because that's a goal of our LHIN, and so I think that they would speak more closely to that.

Mrs. Christine Elliott: Okay. We'll have a chance to speak about it.

The other question I had was, standardizing the experience of the LHINs across the province. Do you feel that the LHINs are receiving the leadership that they need from the ministry? Do you think it would be helpful if the goals of the ministry might be more clearly articulated to the LHINs in order to allow them to provide enhanced services in the areas they represent?

Ms. Elizabeth Bader: I really wouldn't be able to speak to that point. What I can tell you is our experience as community health centres across the province. We have provincial initiatives across all community health centres.

There was an experience that happened a couple of years ago when the LHIN was given a certain percentage increase for budgets. Some LHINs gave the full increase to CHCs, some gave partial and some gave none. What that creates is a discrepancy across the system of CHCs. At that time, some CHCs could give, for instance, salary increases to staff and could expand services that were greatly needed to clients and to patients, but others couldn't. So then there becomes a bit of a competition between CHCs, which we don't want. Questions arise out of process, so attention gets focused on process rather than the delivery of excellent service and the support of fantastic employees. So that's where that's coming from. That's just one example of where it would be important to have some standardization, understanding that there are regional issues that each LHIN has to attend to.

The Chair (Mr. Ernie Hardeman): The third party?

Miss Monique Taylor: Thank you so much for your presentation. You've raised some absolutely wonderful points, talking about prevention, being proactive in health. That is something that, especially in your area of the city, we need.

I would like to know how you find that your community centre is looked at compared to other areas of the city and what the differences are between them. You talked about the standards in treatment. Are you getting treated the same? Are you finding that there are problems between your centre and others?

Ms. Elizabeth Bader: Other community health centres or other primary care models?

Miss Monique Taylor: Other community health centres.

Ms. Elizabeth Bader: No. I think, actually, that our community health centres with our Hamilton Niagara Haldimand Brant LHIN are a very strong group of leaders in primary care. We meet on a monthly basis. We work together with our LHIN. In fact, the LHIN comes to our monthly meetings to have discourse around quality across all CHCs, around opportunities for funding initiatives that are across the LHIN.

I'll give you an example. We noticed that our no-show rate at North Hamilton Community Health Centre was high due to the kinds of clients and patients that we outreach to, and so we delivered a proposal amongst all of the community health centres to the LHIN regarding a reminder call system. Through the data and the analysis of the need, that was funded across all community health centres, which created efficiencies in terms of purchasing power—one RFP instead of seven, better buying power and less training required. That's an example of how all of the CHCs work well together.

The Chair (Mr. Ernie Hardeman): Just half a minute left.

Miss Monique Taylor: Thank you for your presentation. Thank you for the work that you're doing.

Ms. Elizabeth Bader: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you taking the time to come in.

ONTARIO NURSES' ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next presentation is from the Ontario Nurses' Association, represented by Linda Haslam-Stroud, the president. Thank you very much for coming in this morning and helping us with our review. We look forward to your presentation. You will have 15 minutes, and you can use any or all of that for your presentation. If there's less than four minutes left, it will go to the third party for questions. If there's more than four minutes left, we'll divide it equally among all the caucuses. With that, the floor is yours.

Ms. Linda Haslam-Stroud: Thank you, Chair. My name is Linda Haslam-Stroud. I'm a registered nurse, and I've provided care through St. Joseph's hospital here in Hamilton, with Dr. Kevin Smith as my ultimate boss, for some 35 years.

I'm also the proud president of the Ontario Nurses' Association, which represents some 60,000 registered nurses, registered practical nurses and allied health professionals. We're providing care, along with our 14,000 nursing student affiliates, across the health care system.

0950

I'm very proudly here today to talk not about the HNHB in particular but about LHINs. My focus is going to be on some logistical, operational and administrative types of recommendations that we think could enhance the LHINs' operations. In particular, we're looking at improving and safeguarding the professional interests

and practice of our nurses, and protecting the delivery of quality care.

Our starting point for that is effective integration of health care services, which we believe is fundamental. There is still work to be done. Effective integration should be coordinating access to quality care and comprehensive services, in order to provide a seamless continuum for our patients in the health care system.

Minister Smitherman, when he enacted the LHINs some time ago, talked about it being "a comprehensive system of care that is shaped with the active leadership of communities and driven by the needs of the patient." He went on to say, "LHINs are going to help us build a system that has patients at its centre," and that they should be prioritized using the needs of our local patients and communities. I suggest to you that some of our decisions must be guided first and foremost by patient access to a comprehensive health care system, and I think we have a little bit of a ways to go.

Concepts fundamental to integration of health care, such as quality patient care and transparent decision-making made in the public interest, based on our priorities, should be front and centre in the decision-making process. I would suggest to you, rather, that right now integration is understood really exclusively in the blunt language of the act: "transfer," "merge," "amalgamate," "cease," "dissolve" or "wind up" the services or operations.

That's what we're seeing. The focus seems to be on cost-cutting and reducing government expenditures rather than principally reforming the system in the public interest. With due respect to Kevin, there are hard decisions for all of us to make with the limited health care dollars, but the research is out there, very clearly, on how we can invest the appropriate dollars to get the best health outcomes for our patients.

One approach that we're suggesting to refocus the LHINs is through accountability agreements between the Ministry of Health, each LHIN and the service providers. You'll see some recommendations in our submission. What we see as missing from both levels of the accountability agreements is a focus on creating the conditions which are going to provide that quality of care.

The research is evident that quality care is dependent on appropriate registered nursing staffing and safe practice conditions. We know that this is going to improve outcomes for our patients. We believe that there are presently some fundamental oversights in the accountability agreements, which could hopefully improve.

In the submission, you will see some disturbing data that shows that the health care sector has one of the highest rates of illness and injury. If you look at some of the costs, even to the Workplace Safety and Insurance Board—and these are actually the surcharges. This isn't even the premiums that our health care providers are paying.

For three years in the hospitals, how much did it cost in penalties because of the injuries that took place? It was \$50.5 million. Those are dollars that we could be

reinvesting in our patients and having our nurses on the front lines be healthier. For long-term care over two years, it was \$36.5 million, my point being that we have money in the system and better ways of doing things so that we hopefully could reinvest those dollars, to the benefit of our patients.

The accountability agreements do not have any of these kinds of requirements presently regarding health and safety for nurses and other health care professionals, and that is ultimately impacting the quality of the care that we're able to provide. We're recommending that there be health and safety indicators in accountability agreements.

We're also recommending that there be a health human resource plan in the accountability agreements with the LHINs and the providers, and the LHINs to the ministry. I cannot believe that we have the highest number of regulated health professionals caring for patients, clients and residents across Ontario—the nurses of Ontario—and there is not any health human resources plan, either at the provider level with the LHIN and/or the accountability agreements with the LHIN and the government. That is another suggestion that you will see in our submission.

It's embarrassing, actually, that Ontario has the second-lowest number of RNs per patient. I hate to say that, but we need to ensure that it is consistently reminded to you, the decision-makers, that we need a health care system that is going to provide those kinds of high-quality health outcomes for our patients.

The other thing I'd like to suggest to you is access to information in the actual LHINs. You will see that it is basically somewhat of a dog's breakfast. There are different accesses through the 14 LHINs. If you were to look at any one of their websites, you wouldn't be able to really find the information that you require—and I'm sure that in your review, you're probably finding that out yourselves. But I would suggest to you that health care funding announcements, decisions and information should be made available in multiple and consistent ways through the LHINs and certainly through the websites. We believe that right now there is inconsistent access to information. It really is imposing a very difficult task, if you're really looking for input from stakeholders and the patients that we serve. There are improvements in access, consistency and transparency of the LHIN information and of, actually, the LHINs' board decisions, especially around health care funding. We believe that's absolutely critical for public engagement, monitoring of and the involvement of local decision-making.

Because of the multiple funding streams for health care providers, such as in the hospitals, it's really extremely important that we have some way of being able to assess whether the appropriate funding is being provided for our patients on the front lines. Therefore, we're recommending that reports to and decisions on funding and other decisions for every LHIN board meeting should really be easily accessible on the website.

We also are suggesting that to ensure a focus by the LHINs on a quality agenda in the public interest, the

hospitals must actively consult with and provide a strong voice with their fiscal advisory committees for front-line input. We're talking about input to make the system better. So we are also recommending that a requirement in relation to front-line nursing input be part of accountability agreements.

The last thing I want to talk to you about is the integrating of the independent health facilities, and that's a new act, as you know. We are very concerned that the integration of independent health facilities and local planning and the funding of health care under the LHINs is going to be extremely problematic for us as front-line nurses when we see that the extensive body of literature and evidence raises quality concerns where services are delivered in the for-profit sector. We know that consistency and lack of fragmentation of services is to the benefit of our patients, and we don't want to see us going down a road of further fragmentation. We are recommending that enabling LHINs to tender contracts for the movement of clinical services from the hospitals to the private clinics should stop now. A recent one here is looking at the ophthalmology services that we provide very well here in the HNHB LHIN. It also means that we should also be maintaining our community care access centres, and I personally have had the privilege, over the last five years, of having those CCAC care coordinators coordinating care for my two elderly parents—82 and 85 years old. They normally would have been in a long-term-care facility many years ago. They're coordinating everything for my parents to be able to live healthily in the community and in their home together, after 60 years of marriage, so I also wanted to acknowledge the CCACs.

Finally, it is our view that a quality agenda in the public interest requires equality across the sectors. You will know—or maybe you don't know—that unlike other provinces that have parity of wages and benefits for the nurses in the province, we have a piecemeal system and a lack of parity for the nurses that are working in our community. If we want to support the community, we need to attract the nurses into the community, and certainly wage parity, pensions and benefits would be important as well.

I urge the standing committee to seize the opportunity to refocus the LHINs on what matters most to our patients, and that is the delivery of high-quality care. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation, and we're right on the border here, so we do have to circle around. We'll start with the official opposition. You all have about a minute and a quarter.

Mrs. Christine Elliott: Okay. I'll speak quickly then. Thank you very much for your presentation. I gather that you've made specific recommendations for the improvement of the LHINs, so I'm assuming you support the concept of LHINs generally, or I'm wondering if your association has considered any other model as an alternative to the LHINs.

1000

Ms. Linda Haslam-Stroud: We, as nurses—I've been a nurse for 35 years and a leader in health care for 35 years—are used to change. I would suggest to you that the LHINs could work. Certainly, our LHIN here in the HNHB area is probably a better example of how LHINs can work for the benefit of our patients, but I still believe there are a number of improvements that we could be making.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. The third party: Ms. Armstrong.

Ms. Teresa J. Armstrong: Thank you very much for your presentation. I found it quite interesting that you gave a lot of feedback on ways to try to help improve the system that's there now. One of the items that you mentioned was the WSIB cost and health and safety. Could you just give a little more expansion on how you see nurses playing a role in that contribution and how that financial piece could be mitigated so that we can leave the funds where they're needed?

Ms. Linda Haslam-Stroud: The Occupational Health and Safety Act, which all employers are under, is a strong piece of legislation. We need to reduce violence in the workplace. I don't even want to show you the pictures of our nurses with pummelled faces from violence of patients in the emergency departments across Ontario. But the fact is that there are ways to flag patients, to reduce violence in the workplace, to ensure we have a safe system, to reduce injuries, working together—the nurses, the unions in the province and the employer—so that we can mitigate those costs and reinvest them in our patients.

Ms. Teresa J. Armstrong: You feel that nurses, obviously, can contribute to that conversation in order to make—

Ms. Linda Haslam-Stroud: Absolutely. We've had some really great, positive results. Actually, at the Toronto East General Hospital, working with Rob Devitt, the CEO there—I don't know if you know him or not—where ONA, the Ontario Nurses' Association, and the CEO and the employer have worked together to try and mitigate those kinds of costs.

Ms. Teresa J. Armstrong: Okay. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek.

Ms. Helena Jaczek: Thank you so much for your advocacy and your passion on behalf of the nursing profession. It's much appreciated. Certainly, I'm very aware that those issues of health and safety, particularly in the long-term-care sector, are very, very important.

Your recommendation number 3, which relates to the inclusion of public health within the planning mandate of the LHINs: As a former medical officer of health, I just have to ask you to expand on that. As you know, boundaries are totally different—they're based on municipal boundaries—and also, municipalities contribute 25% of the funding for boards of health. I'm just wondering if

you could expand a little bit here and tell us exactly what you mean by that.

Ms. Linda Haslam-Stroud: I understand that there are some barriers, but I think any problem is resolvable in relation to the funding formulas.

If you want to really look at the extensive integrated health care plan, the prevention of disease and the promotion of health are the public-health-principled focus. If we are working together, along with the providers, dealing with the disease, I believe that the public health could work more closely with all the service providers to actually prevent disease, which is going to keep health outcomes more positive for the people of Ontario and reduce health care costs, and we would then have a fully serviced plan.

Public health has been out of the LHINs for too long. We've restructured the CCACs and we still have a way to go, but we're working with those. I believe that the public health, working integrated in the health care system, in the LHINs, would provide better health outcomes for our patients.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's very informative. We appreciate you coming in.

Ms. Linda Haslam-Stroud: Have a great day. I know it's a long one, so thank you very much. Take care.

DEMENTIA ALLIANCE

The Chair (Mr. Ernie Hardeman): The next one is Dementia Alliance: Mary Burnett, chief executive officer. Thank you very much for coming in this morning and helping us with the review of the LHINs. As with the other delegations, you will have 15 minutes to make your presentation. Any or all of that may be used for your presentation. If you don't use it all and there's less than four minutes, the questions will go to the third party. If there's more than four minutes, we will divide it equally among all the parties. With that, the floor is yours. Thank you very much.

Ms. Mary Burnett: Thank you very much. I have packages that are being distributed to all of the members of the standing committee.

Good morning, Chair and honourable members of the standing committee. My name, as you know, is Mary Burnett. I'm the chief executive officer of an interesting organization called Dementia Alliance.

In my presentation today, I want to speak a little bit about who we are and how our formation as an alliance relates to this legislation. I want to talk about the value of local engagement, some of the limitations of the legislation we have experienced, and then end with some concluding comments.

First of all, who we are: The Dementia Alliance is an alliance of the Alzheimer societies of Brant, Haldimand-Norfolk and Hamilton-Halton. We were three small, non-profit organizations that were providing similar services. For example, we provide services to those affected by

dementia and their care partners in our communities with very little infrastructure. Each of our organizations had an ED, but we did not have financial expertise, human resource expertise, and we were very concerned about our ability to address the rising tide.

Given that it's Alzheimer Awareness Month, in your package you will find information on dementia, but if you're not aware, in Canada today, 750,000 Canadians are living with some form of dementia, and that number will double over the next 20 years. One in 11 over 65, and one in three over 85, have some form of dementia. It is the third most expensive disease in Canada, and one that we desperately need a national dementia strategy for.

From a governance perspective, we recognize the need for more strategic management, financial capability, clinical services and fund development.

We also recognize that the LHIN had increasing expectations of our organization from both a reporting and an accountability perspective. So what did we do? We formed a new organization called Dementia Alliance, which is made up of three board members from each of the local societies, and it became the umbrella organization, which is funded by the LHIN.

Some of the benefits we experienced when we integrated—since a lot of this legislation is about integration, I thought I would share with you. Most importantly, in the first few years, we were able to more than double the number of individuals we served without comparable increases in funding. We were much more effective. We were able to look at best practices in each of our communities and borrow those ideas and implement them in others.

We do have more flexibility and we are able to respond at the local level. For example, in a community like Haldimand-Norfolk, which is very rural, we're able to have our staff go into the homes to provide counselling support.

In Hamilton, we now have staff located at the North Hamilton Community Health Centre, which is an area that has its own unique needs.

We have a broader and more diverse staffing pool that can help address some of the unique communities in our LHIN. We have aboriginal staff. We have francophone staff. We have individuals from multiple ethnic backgrounds who speak many languages. Because we now cover a large area, we can call on those resources when needed.

We were able to standardize our practices and improve our performance management. Now we have a director of operations who has developed quality tools, and quality is a big discussion today. I'm pleased to say we now have a quality improvement plan and we're moving towards accreditation. We could not have done this as stand-alone, little Alzheimer societies.

In terms of the actual legislation, I want to share with you an interesting story. When we went to become a voluntary integration—as you know, you have to apply to the LHIN to become voluntarily integrated. So we went through all of the process; we did all the paperwork. We

did everything right, and then what was so strange to both myself and my board members was that the legislation speaks to—the LHIN has the power to oppose an integration from proceeding, but it doesn't speak to anything about supporting integration. That's something you might want to think about when you're looking at the legislation. The letter we got back was, "We're very pleased to tell you the LHIN will not stop the proposed integration," which we thought was a little bit funny.

Now I want to speak a little bit about the value of local engagement in this LHIN. I'm from a relatively small community organization that covers most of the LHIN. In the past, we were not included in planning tables. The hospitals would get together and the community agencies would get together, and the community health centres. Now we have forums where all of these different players and our citizens are coming together to plan for our health care services.

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I was part of the steering committee for the last integrated plan, the action plan, and we had representation from public health, from school boards, from citizens' groups. More and more, the community agencies, which were never included at the tables, have a voice.

So we have a patient flow steering committee that's looking at alternate-level-of-care issues in the hospitals. Thank goodness everyone has realized that community agents have to be a part of the solution, because these people need to come home to the community, and the community is going to be the answer for many of our health care issues in the future.

I also want to share a very exciting process I was involved in with the Behavioural Supports Ontario initiative. We were looking at how we were going to implement services at a community level. There's a long-term-care initiative, but this was at the community level for individuals with cognitive impairment who have responsive behaviour.

So we got together, and a group of community providers met every week for six months. We involved citizens' groups. We involved consumers. And we identified a need for service that was very different than any of us had ever thought we would have generated: There was nothing for families after hours or on weekends. So now we have a community outreach team that's located in our existing mental health crisis teams. We built on existing services, and we're helping to enhance their capacity. So we're very excited about how bringing all these great minds together does make a difference at the local level.

What we are seeing as an organization—you've heard it in spades, I'm sure—individuals want to stay in their homes, particularly older citizens. Recent investments in community care are helping with this, and they're certainly helping to relieve some of the pressures on our hospitals and our emergency departments, and we know that it's more affordable to invest in community care. But our community sector is really struggling these days. We've had frozen base budgets.

For my organization alone, while we've had new services funded, we have to raise \$700,000 every year of

our \$4.2-million operating budget to deliver LHIN-funded services, and I am not unique. There are many other charitable organizations across the province that are in similar situations.

In conclusion, I think the principles of the act are good. We believe strongly in local planning and accountability, community integration and co-operation, but let's not forget that coordination and engagement require time and resources. That's a tough thing to do in times of diminishing resources. I don't know how you're going to do it, but we need to do that work, particularly at the local level, but it takes time and human resources.

We also need to emphasize prevention and health promotion more. I support many of the submissions you've been hearing about the inclusion of public health. We know, I know, as an organization, that if we put money in the front end of the services, and we do more on the health promotion, individuals are slower to develop dementia—we have exercise programs—or they live a better quality of life with chronic illness.

One of the other things I meant to mention is LHIN boundaries. I'm an organization that crosses three LHIN boundaries. That's not easy, and the LHIN boundaries really don't make sense to me. I'm sure they do to you—

Mr. Mike Colle: Oh, they do?

Ms. Mary Burnett: I know there was a reason—hospital discharge planning—but communities think about geopolitical lines. We are the county of Norfolk, or the Halton region, and it's very hard when you're split—Burlington is one LHIN, and north Halton is another, and Norfolk county, God bless it, has a whole corner that's off with London. It's very difficult.

Everybody has the best intentions. Our LHIN, the Hamilton Niagara LHIN, has been very supportive, but it's hard to coordinate services or communicate across LHINs. I have to tell you, I'm a pretty assertive person, and I haven't been successful in really raising the needs of the people in the outlying LHINs as well as needs to happen.

Last, but not least, I want to put in that I think that local solutions are essential in times of diminishing resources. Dr. Sinha certainly told us about the need for strong communities. There's some cool work being done in palliative care that's looking at compassionate communities.

All of that, though, needs also, I think, an investment in volunteer coordination. Nobody talks about that. I want to put a plug in here, because I think the answer for many of us in the future is going to be creating natural systems of support and building communities that wrap services around us as we age.

In your package, you have lots of information on Alzheimer awareness. The Alzheimer Society serves people with any form of dementia. Please take a moment to look through those, and I will entertain any questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about five minutes left, so we will start with the third party. Ms. Taylor.

Miss Monique Taylor: Good morning. Thank you so much for your presentation. Thank you for the work that

you're doing. Hamilton has the largest population of seniors for the LHINs, right?

Ms. Mary Burnett: Yes.

Miss Monique Taylor: —and a growing population, right?

Ms. Mary Burnett: We do.

Miss Monique Taylor: Absolutely. We're aging quickly, and we're going to be coming into what I see as a crisis period.

Then you mentioned that your base funding has been frozen. What are the talks about coming into the future and the need of your society?

Ms. Mary Burnett: I'm sorry. The first part of your question was, what are the—

Miss Monique Taylor: What are the talks that are happening with the LHINs, with the problem of your base funding being frozen and the deficit that you already—I mean, you're fundraising \$4 million a year?

Ms. Mary Burnett: No. We're fundraising \$700,000 of our \$4.2-million budget.

Miss Monique Taylor: Oh, sorry. Okay.

Ms. Mary Burnett: I'm not unique. Many organizations across this province—hospitals—are in the same situation. But I would argue that the community support sector never received the infrastructure funding that larger organizations did. Many of us were voluntary, volunteer-led; we were funded by donations. But now, the needs that have shifted to the community sector are much higher, so we now have all regulated health professionals working for our organization.

Ten years ago, we were more of an information and referral—we were more upstream, as you say—but as the needs of individuals in the community increase, so do the needs for our services.

We continue to fundraise. We have a fundraising professional. We meet with the LHIN. We identify new needs. But I don't think I'm unique in saying that we have a pressure, from an infrastructure perspective.

Miss Monique Taylor: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Mr. Flynn?

Mr. Kevin Daniel Flynn: Thank you, Mr. Chair, and thank you, Mary. Good to see you again. Thank you for coming again. It's good to see you here.

Ms. Mary Burnett: Nice to see you too. Thank you.

Mr. Kevin Daniel Flynn: You've done a great job. Your organization has done a great job alerting the decision-makers to what's going to happen in the future if we don't come to grips with this in a strategic way.

If you can get beyond the boundaries—and sometimes the boundaries make sense strategically and sometimes they make you scratch your head, so I agree with you on that. If you can get beyond that with the LHINs, they seem to be a vehicle where we could make some of the changes that you're asking us to make for your specific issues, for Alzheimer's and related dementia. How could you see us improving that process?

Ms. Mary Burnett: Absolutely. I think that we are going to have to continue to plan at a local level, so it's

really at the community level where we're seeing the biggest gains. When we start to come together as organizations, as faith groups, as neighbours, to support the aging population, we will—I think there's a lot more that we can do, but I think we need to invest in volunteer management—volunteer engagement, not management. We have a huge seniors population that's healthy and well, as Dr. Sinha reminded us. We need to get them engaged in being part of the solution.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation, Ms. Burnett. It's really interesting, and I'd like to follow along with what you were just commenting on. I really believe in the power of local volunteers as well and their ability to support people with Alzheimer's. You're doing great work in the community.

One of the things where I think there's an area for additional support is in respite services. I think there's a lot of volunteer work that could be done there. I'm wondering if you could expand a little bit on how you see volunteer engagement could be very supportive to your organization.

Ms. Mary Burnett: Absolutely. We have respite services that are offered through a volunteer visiting program. We also are building circles of support. When we meet families at the front end of this disease, we tell them, "Don't expect that you're going to get 24/7. You need to start thinking about how you're going to come together to support your family member with dementia, because there aren't going to be enough health care resources."

But I think we need to invest in good volunteer coordinators who can go out and recruit, train, thank and support our volunteers in our communities. All of our clients want more respite, and they want in-home respite, and they need consistency of respite.

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Mrs. Christine Elliott: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It was very much appreciated.

I want to say that, even through the snowstorm last Saturday, our Walk for Memories was a great, successful event. Thank you.

Ms. Mary Burnett: Thank you very much.

VON CANADA

The Chair (Mr. Ernie Hardeman): Our next presentation is VON Canada: Linda Lopinski. Linda is the manager of external relations with VON. Welcome to our committee meeting this morning. Thank you very much for taking the time to come. You will have 15 minutes to make your presentation, and you can use any or all of that for your presentation. If there is less than four minutes left over, we'll go to the third party; if there's more than four minutes, we will divide it equally, starting with the government side.

Ms. Linda Lopinski: Thank you. Good morning, everyone. My name is Linda Lopinski. As has been mentioned, I'm manager of external relations for the Victorian Order of Nurses for Canada and the HNH B LHIN. We are a LHIN-funded health service provider here and in many other jurisdictions in the province of Ontario, as well as being a national charity.

Prior to joining VON, I was with the Waterloo Wellington LHIN as their senior consultant for community engagement. In that capacity, I had the opportunity to work with the Ministry of Health to develop the current LHIN community engagement guidelines and tool kit, and also to conduct many conversations with health care consumers.

It is with that background and experience that I offer my comments today, and I would like to thank this committee for providing me with the opportunity to do so.

As a community engagement practitioner, I applaud the committee's commitment to hearing from a broad range of stakeholders. I come with no new data for you today, but rather to provide you with some street-level perspective that I hope will bring additional context to the data that others have assembled for your consideration.

In following the dialogue in previous sessions with this committee, it appears that there are running themes to the presentations and to the questions. One of those themes is, are the LHINs achieving the integrated health system that we want for ourselves, as Ontarians?

It's no surprise that the review of LHSIA has become a review of LHIN performance. Performance reviews are a valuable way for an individual or an organization to understand the way in which they can refine or improve their work. As such, it's important to see this as an opportunity to review the performance of our entire health service provider community, with the LHIN playing a leadership role.

The LHIN is but one entity within the local health community, and LHSIA also created expectations for us as funded health service providers. That's not to minimize the importance of the LHINs' role in leading the integration of local health.

To understand what we have achieved as a service provider community, it's important to reflect on where we started. Change in health is a big order, and we don't have the option of shutting down the plant to retool. That means that we have to both change service and offer service simultaneously. This requires that our local health service provider community be in a constant state of "plan, do, study and act." It requires that we maintain a culture that is in constant movement and prepared for change. Some may recognize that as the Deming cycle, one of many change-management theories, but one that has demonstrated significant success in other sectors.

It's also important to acknowledge the scope of change that is required to see us achieve our collective goal for an integrated system, and also to recognize that change and process improvement must be continuous.

VON is one of a hundred community support service agencies in this LHIN; add to that 10 hospital corpora-

tions with multiple sites and somewhere in the neighbourhood of 86 long-term-care facilities.

Prior to regionalization under the LHIN structure, each agency worked their own plan, set their own agendas and essentially proposed measurements for their own performance, although they may have additionally contributed to informal networks with no authority to act in concert. However, we are evolving as a service provider community. Since authority for local health service provision was delegated to the LHINs through LHSIA, service providers are required to share plans, partnerships, goals and objectives in an unprecedented manner.

Partnerships and planning that were unheard of even five years ago are happening, including cross-sector conversations. Hospitals are talking to community support service agencies, with greater awareness of the shared responsibility to alleviate the pressures on things like ER services, for example. Agencies are forming partnerships with non-traditional health partners such as social housing and developmental service agencies.

Although we have not yet reached our goal for an integrated health system, shared planning, shared goals and objectives are foundational to achieving this. This can only be accomplished when a local authoritative body such as the LHIN sets expectations for a shared agenda.

As an agency that has invested a number of years in this collaboration, we support the need to continue this dialogue. If it was not to be a LHIN in its present form, the local leadership and coordination role would still be critical to the change agenda. The not-too-distant history supports this. Some excellent work was done by the old district health council: lots of great research and planning. But with no authority to direct health service providers, we moved no closer to an integrated system.

More recently, if you look at the seniors' exercise initiative that was rolled out in 2013, we see an example of what happens when funding is distributed centrally but without the benefit of local intelligence. Kudos to the province for taking steps to better control the investment in seniors' exercise, but this initiative would have benefited from more direct local involvement in the planning process and avoided significant frustration for seniors and their residential care providers.

Although there continue to be concerns and criticism of the LHINs and the health service providers for the manner in which we have fulfilled our obligation for community engagement, I would offer, as a community engagement practitioner, that we are now achieving some aspects of true engagement, because true engagement is not episodic, although events are an important tool for gathering information. True engagement happens when the dialogue is regular and ongoing, and we have seen it develop amongst the service providers and the LHIN.

We have work to do in the area of better engagement with the consumer public, but this is still, in many ways, a developing art and the subject of study and dialogue in the world of professional networks for community engagement practitioners like myself on how to better in-

volve the consumer community, achieving that ongoing, meaningful dialogue while providing individuals with realistic expectations for how their feedback can influence decisions.

I say "can" because "needs" are sometimes synonymous with "wants" with the consumer public—and, in truth, for the health service provider community as well, who are eager to assist by jumping to solutions. However, like individual agencies, one voice does not always reflect all voices, and input can only be informed by our own experiences. Collectively, our goal is a client- or patient-focused system. In such a system, both wants and needs carry weight in the decision-making process. That being said, with limited budgets, there are only so many wants that we can afford, and perhaps these have to be prioritized by need.

The final outcome of that prioritization will always leave someone wanting more or different services. The agency that has the responsibility to set that prioritization will never be popular.

In the discussion of "wants" and "needs," it's also important to recognize the importance of choice in a client-focused system. As a community, we place high value on the concept of choice. An example of this in health can be found in the choosing of long-term-care facilities. Consumers and their families may choose to limit their choice to one facility. There is a cost associated with offering consumers choice in health. With the long-term care example, that cost may be higher ALC rates. As a community, we need to determine whether these costs are acceptable or not and how choice should be weighted in the debate of wants, needs and prioritizations.

With those thoughts before you for consideration, I understand that this committee is looking for recommendations, so I also offer the following for your consideration. As health service providers and the LHIN work on an engagement practice with the consumer community, we believe it is necessary to bring primary care to the discussion and planning process on a more consistent basis. As others have commented, primary care is pivotal to providing care, particularly to the frail seniors who are the service focus for VON's community support services in this LHIN and others. Although some primary care providers do voluntarily work with others, we need this to happen consistently and we need to share goals and measurable outcomes. The voice of primary care is important to the discussion of want, need, choice and prioritization.

To achieve this, the LHINs need authority to require primary care's participation with some form of accountability agreement. Some may feel that primary care already has a responsibility to participate in the process of change. However, responsibility is different than accountability. Responsibility can be given; it can even be assumed. But that doesn't automatically guarantee that accountability will be taken. Accountability agreements are the best way to solidify a commitment to shared goals and measurable outcomes.

Additionally, we would recommend in favour of allowing LHINs to carry funding over the end of the

fiscal year. As a service provider community, the cycle of “spend it or lose it” in-year impacts our ability to plan and execute effectively, as projects are tied to the funding cycle when they should be tied to an implementation schedule that makes sense from a client service or a project perspective.

In closing, I would again thank you for your attention today. I would also like to leave you with a final thought. Some believe this journey started eight years ago; some say four. But one thing is certain: When we started on this path, we knew the destination, but no one provided a map. We’re in a better place than we were. The work is encouraging to us, as health service providers, and it’s important that the collaboration continue. Thank you.

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The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have six minutes, so we have two for each party. We’ll start with Ms. Jaczek.

Ms. Helena Jaczek: Thank you so much for coming in and expressing your thoughts and giving us a good overview of, I guess, all of our desires to see more integration. You mentioned involving primary care, and you’re talking about that through an accountability agreement. You’re an experienced person. You know that physicians are very often, still, in this day and age, solo practitioners and are not used to, perhaps, the type of collaboration that, I guess, we would all envisage. How would you suggest engaging the primary care community with a view to having them understand the value and so on? Could you give us kind of a bit of a road map as to how we might roll this out?

Ms. Linda Lopinski: I guess my comments, in relation to an accountability agreement, actually relate to, again, based on experience, having been on both sides of the fence—both having been on the engagement side of the LHIN fence and also currently working within the health service provider community.

I agree with you: Physicians, as a community, have always been one of the toughest groups to engage. But the reason for that is that they do not see themselves within the accountability chain. They see their work as being related, for sure, and very impactful, of course, to the client care that’s provided, and I think they recognize the impact that it has on funded services, but they don’t feel an obligation to participate in that conversation on an ongoing basis.

An accountability agreement—I guess the way it’s labelled, it sounds very heavy-handed, but it really doesn’t have to be. Maybe it’s a memorandum of understanding, like whatever that relationship has to be. But I think we do need to find some way to actually craft out those shared goals. Like many other situations, sometimes having a commitment to something on paper actually makes it easier for people to stay focused on the same goals and ensure that we’re having the same conversation.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation today, the good solid recommenda-

tions. I’m interested in the second one, actually, about allowing the LHINs to carry forward funding from year to year. It certainly makes sense from a planning perspective. If you want to do beyond one- or two-year planning, you need to be able to have the funds to be able to carry it out. I’m wondering if you could give us a little bit more of an understanding of how you would see that happening.

Ms. Linda Lopinski: Well, I’ll give you a direct example of what happened this year. We were successful in our application to the LHIN to receive funding for a new project that is focused on seniors with developmental disabilities. This is a community that has not gotten a lot of attention. As a matter of fact, this is not a community that anyone even planned to exist. People with developmental disabilities often did not live past their forties. We are now seeing seniors in the community who are in their sixties living with their 80-year-old parents.

We did propose to the LHIN, with a community investment round this summer, that such a project be implemented. We are moving forward on that basis. It puts a different kind of pressure on us as a health service provider to ensure that that has to happen within the funding year, because now—even though it’s new; it’s a new community; it’s a new program—we have to also plan to have this implemented before the year’s end to ensure that the money is spent within that funding cycle.

If the LHIN had the opportunity to actually carry that money over, we could perhaps plan more effectively and take the pressure off, because some of—I wouldn’t say they’re barriers—the things that are creating some pressures for us are, we’re working with Developmental Services Ontario, which is an MCSS-funded agency. They do all the intake and the assessments for seniors who have developmental disabilities in relation to their support needs. They do a fulsome—their assessments are four to six hours in length. There’s only so many of those that they can actually fit in within their system, and they aren’t funded by us, so they answer to another ministry entirely. So we’re putting pressure on them; they’re not necessarily able to—

The Chair (Mr. Ernie Hardeman): I’m sorry to cut you off; we’re very stuck on the time.

Ms. Linda Lopinski: My apologies.

The Chair (Mr. Ernie Hardeman): Miss Taylor. Oh, Ms. Armstrong.

Ms. Teresa J. Armstrong: Thank you for presenting. I found your suggestions quite interesting and very forward-thinking with regard to engagement and how it best accomplishes the goals of an agency to continue, change, plan and so forth.

One comment I was interested in was your senior exercise program. You had mentioned how that could have been done better. Can you elaborate on that, how that would have benefited your agency if there was—the perspective from what you can see—more consultation and more engagement?

Ms. Linda Lopinski: In this LHIN, VON is a service provider for the falls/exercise initiative in 80 locations.

What we found is that when the funding was announced and when things began on August 1, we didn't necessarily have a fulsome understanding of the community in which we were working. Although the province planned—again, the numbers all work and it's great, but we're going to have exercise classes that have 35 people in them and they're going to be open to the public. There wasn't necessarily an appreciation for what was happening at the residents' end, where a retirement home may only have a room that holds 15 people, and there are hoops to be jumped through in terms of allowing people from the outside in, right?

We have now jumped a lot of those hurdles, so I think things are going very well now. I think it got off to a bit of a rocky start, and I actually had to spend a fair bit of time myself travelling around to those locations in the LHIN, helping seniors to understand what we were trying to accomplish and how they were going to benefit from it. If we had been able to perhaps execute on some of that education first, and then introduced the initiative and took into consideration the limits on room sizes and all of those kinds of things, it would have rolled out more smoothly than it actually did.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate your insights.

Ms. Linda Lopinski: My pleasure. Thank you.

MR. JOE McREYNOLDS

The Chair (Mr. Ernie Hardeman): Our next presenter is Joe McReynolds. Thank you very much for joining us today and putting your time in to come here. We will have 15 minutes for your presentation. You can use all or any of that as you see fit. Any time left, if it's less than four minutes, will go to the third party, is it? Anyway, it will go to somebody. If it's more than four minutes, it will be split equally among the parties. With that, the floor is yours, and we thank you very much for being here.

Mr. Joe McReynolds: Thank you, Mr. Chairman and members of the committee. Good morning and thank you for the opportunity to present. You're getting a copy of my presentation and, as you will see on it, I'm somebody who has spent almost 50 years in the human service sector, so I come to you with some expertise from learning what I've done through those years. I was a founding chair of one of the LHINs, so I have the experience of doing that. I've been in a district health council system. I've been throughout the provincial government for a number of years etc.

What I come to you today about is to support the concept of the LHINs because health care is a very extremely complex system. Our own health system is a very amazing system in itself; it's so complex. The structure: We have thousands of independent providers in this province and the nature and the size of those providers vary greatly. Across the world, there's a change going on from a medical model to a population health model.

These changes all make the delivery and planning of health care very complex. So we need, in Ontario, a system that will establish a process for planning and delivering services at a local-based level. The LHINs are a tool to do that. I believe, personally, that they are the powerful answer to the requirement we have to deal with the complex system that we have, but they must be given more freedom and more authority if they are to build a sustainable health service system.

Other provinces, as you probably know well, control and staff their own services. Ontario has chosen to harness the resources of communities through local boards and service units and, with this approach, it makes tasks for the system coordination and system integration much more challenging. But I believe the value of the local control and the involvement of local volunteers and resources help the Ontario approach to be more aware of and more responsive to the needs of our local communities and local residents. For that reason, I think we need that process, and I think the LHINs are a good start in that direction.

Now, I'm not going to speak to why I value the LHINs because I think you can read it. They're good system planners, they're excellent system managers in the service accountability agreements, as an example, that happen now across the province. What we experienced when we started the LHINs were many deficits occurring. Today, you do not find those deficits in the health care system. That's a result of the impact of the LHINs in our system. They're obviously engaging local communities and, I think, doing an excellent job of that, and they are a neutral body of change. They really do, in their Integrated Health Service Plan, provide one of the best planning models that we see probably in the world. The depth and the comprehensiveness of those planning processes really gives anybody who has the time—and I must say, it does take a lot of time to read them, because they are up to 1,000 pages in many cases. So if you have the time to read them, you get an incredible view of what's happening in your local communities.

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Okay, let's move on to what I think should be changed, what I would recommend to you.

First of all, I would implement all the authority that is in the current legislation. LHINs were supposed to be able to allocate and reallocate resources to provide the goals of an integrated health services system plan. What I see happening after eight years is a continuing failing to change policy and practice that would allow the LHINs to allocate and reallocate funds to implement their plans.

Amongst you, as the political leaders, I see little support for or discussion of this aspect of the legislation. One example is the use of surpluses, and the previous speaker addressed that. The legislation does allow that, but currently, it has never been implemented.

Further, there were some examples in the early years of some discretionary funds being made available to the LHINs to be able to do the kind of change that has to occur. That's what the legislation expects. There has

been a reluctance in the system to do that, and a lack of support across the political parties. We are still dealing with what I believe is a quasi-regional office approach these days. It deserves much better from all of us at the moment.

Second, I'd expand the mandate of the LHINs to include primary care and public health, and previous speakers have spoken to this. Certainly, from a primary care point of view, unless we have the physicians and other care providers in the room, in the planning processes and in the management planning processes, it will not happen. Health links is an excellent example of moving in the right direction, but the leadership of primary care must be part of the planning process and they must be managed, along with the other health care services. The LHINs should have primary responsibility for that.

Everyone speaks about health promotion and well-being as part of the health care system, but our primary vehicle for public health remains outside the discussion. The ministry is currently recognizing the necessity for a stronger community health system, but the remaining foundation piece, the public health, which helps people understand what good health means and how to stay healthy, is not included.

As a member of the board of Health Nexus, which is a national organization that advances healthy communities through community development, early childhood development and aboriginal maternal health, I experience how much outside the system health promotion really is. Bringing the leadership and expertise of public health into the responsibility of the LHINs will move the health care system in the right direction.

Third, I would encourage the governors and senior directors of the LHINs to continue to plan a local health system within a provincial health care system, so that there is a common approach to system planning, system management and system change. It's all about systems.

In the past eight years, we have been challenged to ensure that there's a common approach to the roles and responsibilities of LHINs. Initially, there was a great emphasis placed on the local nature of LHINs. LHIN governors and executives are increasingly working to plan and manage in a more coherent manner. LHIN leaders need a legislative mandate to strengthen their collective partnership, so that residents can expect the same standard of service wherever they live in Ontario. This would allow LHINs to continue to explore how to manage the health care system collectively, while preserving the requirement to address local conditions.

Finally, one of my own pet peeves: Add the responsibility for ensuring not only that residents know about services, but that in every community, there's a way to help persons acquire the help to get services they need through what I would call system navigation for clients. At every community event I've ever attended, the common voice of the residents is that there's a need to find out what services are available and a need to help them manage navigating the system. Depending on the complexity of the need, this assistance can be delivered

by a care professional or it can be delivered by a trained volunteer.

We are beginning to see the evolution of navigation across the province, but as the needs become more complex and there are more providers involved, we need somebody to help guide and sometimes advocate for us. LHINs should be mandated to ensure that the community has the necessary services of client system navigation.

I thank you for letting me share my thoughts with you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about six and a half or seven minutes left. We will start with the official opposition, and we'll have two minutes each.

Mrs. Christine Elliott: All right, that's great. Thank you very much, Mr. McReynolds, for your comments. You've raised some really interesting propositions. This concept of system navigators: Certainly we've heard a lot about that in the mental health and addictions select committee and currently in the developmental services select committee. I think there's certain client populations that will always need to have system navigators, but I think the system navigators in general health issues probably should be looked at as more or less a temporary thing until we get it sorted out. We should be able to have a system that people can navigate themselves. We've made it unduly complicated, I think, in some respects.

Mr. Joe McReynolds: Certainly, 75% of us should be able to find our way through the system if the system is clear enough to us; I don't disagree at all. But, as you say, it's the individuals who are suffering from various disabilities as well as the seniors who require some support and help through the system.

I have a daughter who is working in a TeleCheck system. They deal with 125 seniors a day who they check with—they check both physically and mentally where those seniors are each day, but they also help guide them through it. This is the kind of thing we have to see across the province if we are really going to deal with our most vulnerable people in our society.

Mrs. Christine Elliott: I agree with you entirely.

Do I have time for one more question, Chair?

The Chair (Mr. Ernie Hardeman): Very short.

Mrs. Christine Elliott: Okay. The other concept is that you talk about encouraging the governors and the senior executives of LHINs to work together to make sure that we have a common system across the province with variations for local conditions. Surely there's also a role for the Ministry of Health in that regard to set the tone, to establish the priorities, which the local organizations can then deliver upon. Could you comment on that and how you see the ministry fits into that?

Mr. Joe McReynolds: There's certainly no question that the government is responsible for setting direction and design in where we're going. But what I'm talking about is finding a way to help the LHINs have a more coherent process across the province. It may be as simple as putting something in that says they will produce an annual provincial report, as a group, about where they're going. I'm not sure, but we need to support that. A lot of

work is being done by the LHINs to do that, but it needs to be more.

The Chair (Mr. Ernie Hardeman): The third party: Ms. Armstrong.

Ms. Teresa J. Armstrong: I'm getting a little worried because I'm having some like-minded questions with the Conservatives here.

Interjection.

Ms. Teresa J. Armstrong: Yes, I think so.

One of the questions I had, and I'd like to maybe probe this just a little bit more—you talked about the need for navigation within the system. I actually did a health consultation, I can't recall when—in the last two years—where that was a very important piece. Where do you see that navigation happening for assistance with people wanting to enter—well, they're forced to enter the health care system. Where do you see that happening? At what point does that help the patient or person?

Mr. Joe McReynolds: At what point?

Ms. Teresa J. Armstrong: At which point should that service be offered to them? Where should they access that service?

Mr. Joe McReynolds: For me, it happens in the local community, when they are at the point where they are looking for something. We may be able to educate a good neighbour in the community to do that. We may need a professional, depending on the complexity of it. But the LHINs should make sure that, in every community, that kind of a system exists, is what I'm saying.

Ms. Teresa J. Armstrong: Okay. The feedback that I had gotten was, when people are in the hospital, that's when they're most in need of that information. They're not feeling well, and that's when all the information comes to them; it's bombarded to them. Most people aren't going to look for that navigation assistance until they want it, until they need it, right?

Mr. Joe McReynolds: There are those who are in the hospital who require supports—

Ms. Teresa J. Armstrong: Yes. It's at a crisis point there.

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Mr. Joe McReynolds: And the hospitals have and continue to try to make that linkage with the communities etc., but for people who are in the community who have mental health problems or are aging etc., it's more of a gradual process.

Ms. Teresa J. Armstrong: Okay. So you see that out in the community, not necessarily in hospitals when people are in crisis.

Mr. Joe McReynolds: I see it more in the community.

Ms. Teresa J. Armstrong: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you very much. Mr. McReynolds, I've just been waiting for someone just like you to come before us, because this is a question directly related to the legislation.

I'll share my bias: The chair of my LHIN has found that the need to have a health professionals' advisory committee, which is specified in the legislation, hasn't really panned out to be what was anticipated. In other words, there does not seem to be a real utility to having that committee in place. Could you comment, from your experience, on how that worked and how you feel about that being in the legislation?

Mr. Joe McReynolds: Well, I'm probably going to insult some of my friends on this one. I mean, it was put in place at a time when there was a lot of small-p activity going on in the LHINs etc., so it was put in place to really be expert advice to the executive levels of the LHINs. I think we lost a little bit by not finding a way to link it to the governance levels of the LHINs as well.

Perhaps that is what's going to make the difference, because I think that's where there's a feeling—nobody's really nailed it down, but there's a feeling that they are not as effective as they could be. I think it's because it tends to be more of a technical advisory committee at the moment.

Ms. Helena Jaczek: So would you see actually having the chair of that advisory committee sit on the board of the LHIN, or how would you—

Mr. Joe McReynolds: Now that's an interesting idea. It could happen that way, but they certainly should be invited in on a regular basis to have dialogue with the boards of the LHINs if they don't have direct representation.

Ms. Helena Jaczek: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Thank you very much for your presentation. We very much appreciate you being here.

Mr. Joe McReynolds: Thanks.

HAMILTON HEALTH SCIENCES

The Chair (Mr. Ernie Hardeman): Next is Hamilton Health Sciences: Murray T. Martin, president and chief executive officer. Thank you very much, Mr. Martin. We very much appreciate your time coming in this morning. As with other delegations, you'll have 15 minutes to make your presentation. You can use any or all of that time. If there is time left over, less than four minutes will go to an individual party; more than four minutes, we'll split equally to all caucuses for questions. With that, thank you very much for being here. The floor is yours.

Mr. Murray Martin: Thank you, Mr. Chair, and thank you for the opportunity to present today. Hamilton Health Sciences is the organization that consists of McMaster Medical Centre, McMaster Children's Hospital, Hamilton General, the Juravinski Hospital and Cancer Centre, St. Peter's Hospital and Chedoke Hospital, and we were just advised a couple of days ago that our amalgamation with West Lincoln Memorial Hospital has now gone through.

That makes us one of the largest health care organizations in Ontario, and we actually provide the broadest range of services of any health care organization in

Ontario. This is particularly an honour as it, in actual fact, will be my last official duty, as I actually retire this Friday after 43 years in health care.

I was actually raised in Regina, Saskatchewan, and I recall when Premier Douglas introduced medicare in Saskatchewan. My family moved to a new neighbourhood, and our next-door neighbours were a family doctor who was in private practice, and our other neighbour was the doctor the government brought in from the UK to set up community clinics in the province. I had the honour of shovelling both of their driveways; they both paid very well—one, of course, for the season and the other on a shovel-by-shovel basis. That was my first health care experience.

In my 43 years, I did work 13 years of it in Saskatchewan, 10 years in British Columbia through multiple versions of regionalization, and then the longest stretch, 20 years, in Ontario. During that time frame, I've certainly seen a great deal of change: In my 10 years in British Columbia, there were three versions of regionalization. That was between 1991 and 2000, so certainly the LHIN structure in Ontario has been relatively stable to change in health care structures elsewhere in the country.

What I've experienced being, in my mind, the key driver of success—yes, it does have to do with structure, but it more than anything has to do with relationships. I believe that, within our province, with the LHIN structure, where relationships have been strong, you've seen strong deliverables from the LHIN. I have a particular bias, in that I do believe our Hamilton Niagara Haldimand Brant LHIN has been, if not the most successful LHIN, one of the most successful LHINs in this province. That is because of the fact that 25,000 health care providers in our LHIN see themselves as all being part of one team, with common goals and a very, very strong sense of partnership.

The relationships have been built around trust and a common purpose, but there truly is an understanding that we all collectively want to achieve the same things for our population that we serve. It is recognized that around the world, it's a challenge for health care systems everywhere to cope with the rate of change and the growing demands on health care services and the financial limitations that exist everywhere around the world.

One of the reasons that I do believe LHINs have been successful is that they've actually given us some defined geography within which it's understood that we are collectively accountable. When I first came back to Ontario in 2001, prior to LHINs, individual hospitals saw themselves as individual entities with accountability only to the province, and they didn't see a greater sense of accountability within a community.

Within our LHIN, we actually have the highest capture rate in the province. What that means is that we service within our LHIN 92% of our population, meaning far fewer than many others need to go outside of our LHIN. We have a LHIN that has critical mass. In actual fact, to do things, to drive efficiencies, you do need scale and to have that scale, again, you need critical mass. That

does allow you to create centres of excellence and drive efficiency. We do recognize that—or maybe it's not often recognized—that the size of our LHIN, with a million and a half people, is actually larger than six of the provinces. We do have that scale, and, again, I do believe that is essential.

For the future, what I'd like to see is the system move to a more decentralized model with autonomy at the LHIN level, and I'll use my example dealing with local issues, such as alternate-level-of-care patients. Our own experience in our LHIN is that the ALC issue was not an issue elsewhere in the province until it became an issue in Toronto, because there is this, in our belief, over-focus on the needs of Toronto, and then solutions are created in response to what may be going on there.

Two recommendations that I would make, and this does come from my experience, particularly in British Columbia, are that I actually do believe that public health needs to become part of our LHINs, and also, I'll add in the ambulance system. I actually believe the ambulance system should be part of LHINs. My early years in British Columbia, they were part of the municipal level, and it was simply done on the basis of trading of greater responsibility for—one service that the province held was transferred to the municipal level in trade for the province taking over public health and LHINs; I think it was in the communications sector. So it certainly is doable and it would, I think, recognize the key roles that those services play in our system.

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The ministry's role needs to continue to focus on providing health system goals and on the development and accountabilities around standards. There are perhaps some changes to the act that created LHINs that do need to be made, but overall I actually think that the act is fine. The act outlines a robust way to decentralize, but I do not actually believe that it is executed in the spirit that it was originally written and certainly not in a spirit of decentralization. We still see a lot of one-size-fits-all; there is a perspective of the need for centralization. In my time in health care, I've seen health care become far more bureaucratic than it was in the past or than I believe it needs to be.

We have seen that the outcome of the focus on issues like eHealth and Ornge is to implement centralized contracts to try and ensure no recurrence, but I do believe there's little thought that, at times, the cure can become worse than the disease itself. It does have an impact of stymying innovation, and we really have to do a better job of thinking through what we're trying to achieve.

Living and working across Canada, I do know that the people of Ontario are blessed with an outstanding health care system, made possible through highly skilled and dedicated health care providers. I am a strong, strong supporter of the role and value of LHINs. I do believe that they can be strengthened, but in that strengthening, it has to be part of a willingness on the part of government to live with a more decentralized system to allow LHINs to achieve what they were originally set up for.

Thank you very much for the honour of presenting.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have two minutes for each caucus. Remember, as you get to the last question, the answer has to be part of that two minutes. We start with the third party.

Miss Monique Taylor: Thank you so much for your presentation. Congratulations on your retirement. I know you've worked long and hard for that, and I hope that you'll keep in the health care realm as you move forward.

It was interesting that you brought up the ambulance service and how that should be brought into the LHINs. I know that here in Hamilton, with the changing of McMaster hospital into a child emergency centre, the paramedics were a big factor when it came to the city and the extra costs that were put on the city with the change in the paramedics and the increase of their budgets. Can you expand a little further on that?

Mr. Murray Martin: It is a matter of incrementally—some parts of the system's costs may go up, but if it actually achieves the overall benefits. I am obviously a strong advocate that what we achieved around our service realignment—people are far, far better off as a result of that. There were certainly offsetting costs in other parts of the system that more than accommodated the increased costs of the ambulance system.

But through that process, it would be, to me, a best example had we been part of the same accountability—that that would have been far easier to accomplish and we could have come up with perhaps even some more effective ways of dealing with it.

Miss Monique Taylor: Because as it sits right now, those costs went onto the municipality. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Mr. Flynn.

Mr. Kevin Daniel Flynn: Thank you, Mr. Chair, and thank you for your presentation. It's only Tuesday; you're retiring on Friday. What are you doing for the rest of the week?

Mr. Murray Martin: Believe it or not, I actually have a board meeting on Thursday night.

Mr. Kevin Daniel Flynn: Best wishes for a really happy retirement.

There seems to be—I'm just sitting in on the committee for the day—a sort of common thread emerging just from the presentations I've heard in Hamilton this morning, in that it's a good framework; it's a sensible process; there's room for improvement. You want to bring in primary care; you may want to bring in public health. I live in and I represent a riding in the Mississauga Halton LHIN, and I've had a tremendous relationship with my LHIN. Anytime I've had to work with the Hamilton Niagara Haldimand Brant LHIN, the response has been tremendous as well.

So I'm wondering—we're talking about the accountability to LHINs of community care or agencies—where do you think the accountability of the LHINs should lie and where should it go?

Mr. Murray Martin: I didn't touch upon primary care, but it's very, very clear to me that there needs to be a stronger alignment of the primary care system with LHINs. It's obviously going to be a challenge to actually get there, for reasons that were referred to earlier, but that is a disconnect. I think when the Canadian health care system is compared to particularly European systems, it's because of that misalignment that we don't do as well and fare as well as other health care systems. I think it is absolutely the elephant in the room and that we have to come up with an effective way.

At the end of the day, the government pays the \$11 billion that pays physicians, and so it has to be able to define what it expects, from an accountability point of view, for that money spent.

The Chair (Mr. Ernie Hardeman): Thank you very much. The official opposition: Ms. McKenna?

Mrs. Jane McKenna: Yes, and I'd like to also echo out what other people have said. When we hear your name mentioned out in the community, you've been a staple for us and you will be missed. You have worked extremely hard for Hamilton Health Sciences, and we are very grateful for all your hard work and dedication. So for that, I'm very grateful and thankful.

You said that the act is fine but the spirit of centralization is not. Can you just elaborate a bit on that?

Mr. Murray Martin: There's the inability to problem-solve at a local, regional level. So if we look at our alternate-level-of-care issue, unless it fits into what the provincial strategies are, it almost feels like hit-and-miss as to whether we make progress.

There would be the ability, in terms of moving resources out of acute care hospitals into the community, if we could actually use that money, to actually create the resources that we need. But that's really not possible within the stovepipes that our system still operates. That would be the biggest and the best example that I could think of.

Mrs. Jane McKenna: If there was one thing—for 43 years, you've been doing this. You would be a wealth of information, with all the things you have seen. What is the one thing that you can think of for us today, to take back, to make the system better? I guess that's kind of a hard question to ask, but what would be one thing, just off the top of your head, that would—

Mr. Murray Martin: The one thing, to me, would be the stronger alignment of the primary care system with the goals of the overall health care system. That's where you'll make your greatest level of progress.

Mrs. Jane McKenna: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation today, and good luck in your next career.

Mr. Murray Martin: Thank you very much, Mr. Chair.

The Chair (Mr. Ernie Hardeman): I'm sure there's one out there waiting. Thank you very much.

HAMILTON NIAGARA
HALDIMAND BRANT
LOCAL HEALTH
INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Next is our Hamilton Niagara Haldimand Brant Local Health Integration Network: Donna Cripps, chief executive officer. Good morning, and thank you very much for joining us this morning. As with the previous delegations, you will have 15 minutes. Use any or all of it for your presentation. Anything that's left over will be used in questioning from the caucuses.

Ms. Donna Cripps: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you. The floor is yours.

Ms. Donna Cripps: Good morning. It is indeed an honour to be here. I'd like to thank the members of the standing committee for this opportunity to address you today.

My name is Donna Cripps. I'm a wife, a mother, a daughter and a sister, and in all those roles, I've either been a patient or a family member who has experienced our health system.

I've also had the opportunity to be a provider within our health system. I was a registered physiotherapist who had the privilege of providing hands-on care to patients for more than 25 years. I continue to be a proud health care leader, formerly as the president and CEO of St. Peter's Hospital in Hamilton here, and currently as the CEO of the Hamilton Niagara Haldimand Brant Local Health Integration Network.

Our LHIN holds accountability agreements with nearly 200 health service providers that, together, deliver over 230 health programs and services, with funding of more than \$2.8 billion. These programs are offered to the more than 1.4 million residents who live in the approximately 7,000 square kilometres that constitute our LHIN.

Today, I want to take time to tell you a story, a real story, of one of our residents, Bernice. While the story is accurate, I have changed Bernice's name and some identifiable information, to protect her identity. If there's one thing I hope that you can remember from today, it's the story of Bernice.

Bernice lives alone in her own home in a smaller, more rural community in our LHIN. The CCAC visits her every week and her children visit her frequently.

One day, Bernice falls at home and suffers a serious cut on her arm. Paramedics are called and Bernice is taken to the local hospital. The team in the emergency department treated her arm. She was discharged home the same day. Unfortunately, Bernice was unable to use her arm when she got home. She had trouble getting her meals, getting dressed and managing her daily activities. There was no follow-up planned and no information was shared with the CCAC or with her family doctor about her visit to the hospital. As it turns out, this fall was a foreshadowing of things to come.

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In fact, over the next 12 months Bernice had a number of falls at home, one of which resulted in a fractured hip. Again, Bernice was taken to the local hospital. It's a small community hospital, and it did not have the expertise to treat her badly broken hip. Bernice waited three days with a broken hip in her local emergency department; it took that long to find a larger hospital that could accept her for the surgery she needed. During that time, she lay flat on her back on an emergency room stretcher. Can you imagine how she must have felt? She was finally transferred to a larger community hospital for hip surgery. Bernice spent six months in hospital recovering and, sadly, her physical condition deteriorated significantly to the point that she could no longer return home and she was eventually discharged from hospital to a long-term-care home.

I'm afraid stories like Bernice's have been all too common throughout Ontario. While every part of the system provided quality of care for Bernice in their individual silos, when you look at Bernice's experience over time, you can see that the system did not treat her very well. In fact, if we cost out the care for Bernice from the time of her first fall and for five subsequent years, we see that the health care system costs were roughly half a million dollars, and the experience for Bernice was not acceptable.

At our LHIN, we're committed to dramatically improving the patient experience for every single person. This means that we need to change every part of our system, change the way we think and change the way we act. That is exactly what we're doing.

Over the past four years, and with the support and involvement of health service providers from across our region, changes have been implemented that would make Bernice's experience very different today. Let me quickly explain how Bernice's experience would play out in today's system.

As you know, Bernice lives alone in her own home in a smaller more rural community in our LHIN. The CCAC visits her every week and her children visit her frequently. One day, Bernice falls at home and suffers a serious cut on her arm. Here's where things start to become different. This time, the paramedics arrive at her home and they are able to treat her appropriately at home. They don't need to take her to the hospital. The paramedics contact her family doctor to inform him of her fall. Her doctor makes a notation of Bernice's fall on her electronic health record—we call it ClinicalConnect. The notation by the physician automatically flags the CCAC of a change in status of one of their clients. The paramedics suggest that Bernice might benefit from a geriatric assessment. The Geriatric Outreach Team comes to Bernice's home where they meet with her and her family. They make a number of recommendations to her physician for medication changes that will better meet her needs, as well as suggest that Bernice enroll in the local physiotherapy falls prevention class that has recently started at the local seniors' centre. At these classes,

Bernice meets other ladies her own age and gets involved with other activities at the centre. Bernice continues to live at home on her own for the next three years and continues to attend various programs at the centre.

Unfortunately, one day as she's leaving the Wii bowling tournament at the centre, she slips and breaks her hip. Again, an ambulance is called and she is taken to the local hospital. She is assessed by staff, and it is quickly determined that they do not have the expertise to treat her badly broken hip, so they call their buddy hospital, a larger community hospital, and within eight minutes, Bernice is on her way to a hospital that can care for her. She is received at the emergency department, without wait, and she is immediately admitted and has her surgery prior to the end of the day. Within 36 hours, Bernice is transferred back to her community hospital for her recovery. Bernice receives care within an Assess Restore Program. This program has been designed to care for older adults. They focus on improving Bernice's functional ability so she can return home. Bernice stays in this program for one month. This time has allowed her to recover to the point that she can return to her home with ongoing support from the CCAC, and it is expected that Bernice will be able to remain safely and happily in her home for many years. This is not a fairy tale; this is not a dream. This is, in fact, how care is being provided in our LHIN today.

So you're probably wondering, if it cost half a million dollars before, what would Bernice's care cost now? Well, we did that math, and this model of care would cost just over \$130,000. Compare that to a half a million dollars: that's a difference of \$370,000. While understanding that the new model of care provides reduced costs, I hope that you agree that Bernice's experience today is much better than it was before, and, really, that's what's most important.

Bernice's story helps me to illustrate to you what our LHIN does every single day. We bring providers together, from all sectors in our health system, and we work together—we coordinate; we integrate—issue by issue, to determine how, together, we can make the experience better for the people we serve and still provide better value to our citizens.

Before the LHIN, the providers—and I was one of them—quite correctly provided excellent care within their own silo. Now with the LHIN in place, it's no longer acceptable to look at the patient as a fractured hip or a heart attack. We must look at the person we serve. We must look at them as a person with unique circumstances. We must focus on the journey throughout the system.

While our LHIN is well known to have one of the seven wonders of the world in Niagara Falls, I believe we also have the eighth wonder of the world in the outstanding academic hospitals in Hamilton as well as nearly 200 health wonders in our world in our health service providers. In fact, earlier this month, a patient at one of our hospitals in our LHIN was quoted in the local paper as saying, "Everybody raves about the patient care

here. And they were right. It's amazing. The staff here are phenomenal." And I agree.

But we also know that there are people in our communities who don't think the LHIN is doing enough to change the way health care is provided or who think we've changed health care too much and who, quite frankly, hate the LHINs. I use that word carefully, but I understand that it has been used at the committee hearings.

We would be completely out of touch with our communities not to recognize that in our LHIN we have made some unpopular decisions. To be frank, we'll probably have to make unpopular decisions in the future. We know that change of any kind is hard to accept, but we know that if we don't change course, health care spending will eat up 70% of the provincial budget within 12 years, so we must do things differently.

Doing things differently often means evaluating our past practices. It means putting new processes, systems and programs in place to support the needs of our communities. We are an organization who challenges ourselves to continuously improve and evolve. We need to learn from our past so that we are better for our future.

For example, the Ombudsman provided a report to our LHIN in 2010. This report was pointed. It made clear recommendations to the ministry and to LHINs. We took seriously his recommendations and quickly addressed them and adopted all of the recommendations.

More recently, we had a request from a local media outlet to release our board materials in advance of a board meeting. To ensure consistency across all 14 LHINs, we spoke to our colleagues and decided we would post our board package the Friday before a board meeting. This has been implemented for our January board meeting.

I apologize to our communities if they felt that we were not as transparent as possible. I can assure you that we will continue to learn more about our communities' expectation of us, and we will continue to implement changes and continue to do better.

I want to take some time now to tell you a few of our local initiatives. With our health care partners, our LHIN has been able to implement a one-LHIN-wide cardiac program. This program is offered on multiple sites. The cardiac care you receive at the new hospital in St. Catharines is the same care you receive at Hamilton General Hospital—one program, great quality, offered on multiple sites.

We've implemented CriticalLink, which partners smaller and larger hospital emergency departments for improved access to care. Smaller hospitals have been buddied with larger hospitals so that the transfer between hospitals is seamless for the patient. That's what Bernice would experience, and I believe Dr. Remington spoke to you about that yesterday.

We've developed 11 health links across the LHIN geography. Health links are about providing consistent and, some would say, the same care in every geographic area of the LHIN. With health links, we are working with

all of our providers, including primary care and some other providers as well, to better, and more quickly, coordinate care for our communities.

We've implemented an electronic health record called ClinicalConnect. ClinicalConnect connects all of our hospitals, our CCAC, our community health centres and our family physicians. It connects them all together. This means that a patient who has received care in Hamilton can go to their family doctor in St. Catharines and, in real time, that family physician can read the notes of what happened in Hamilton. It's truly amazing.

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These and many, many other programs and services that we, along with our health care partners across our LHIN, have put in place are making a difference. While we are not where we want to be, we are seeing results.

When LHINs started out, nine out of 10 people requiring an MRI scan in our LHIN waited up to 124 days. That time has been reduced by 67 days. That means that people are getting their MRI scans more than two months sooner than before the LHINs. Having timely access to these scans decreases the time that our residents anxiously await their results. But they're still waiting 57 days. That's not good enough, and we need to do better.

Our wait times for hip and knee replacement surgeries have been reduced from over 14 months to eight months. While that's six months sooner than before the LHINs were in place, we still need to do better. I have our performance information here with me. If you'd like to see more, I'm happy to leave that for your information.

Have we met all of our performance targets? No, I'm afraid we haven't. Have we made some mistakes along the way? We have. But are we making a dramatic difference for our residents? Yes, we are. Our work is not done. There are many, many more examples, like Bernice—I know your offices hear about those examples—where we now need to focus. But we're on the right track, we're making progress, and we are creating a health system that works the way a system should. My family and I live in this LHIN. We need to continue to bring better care to families like mine.

I've appreciated this opportunity. Thanks for your time. I'm happy to answer any of your questions.

The Chair (Mr. Ernie Hardeman): There's really not enough time left over for a question and answer. We will review your information as we go through this process. Thank you very much for your presentation.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Ernie Hardeman): Our next presenter is the Registered Nurses' Association of Ontario: Doris Grinspun, chief executive officer; and Tim Lenartowych, special projects manager, office of the chief executive officer. Welcome. You will have 15 minutes to make your presentation, and you can use any or all of it. If there's any time left over, we will have questions from our panel.

Ms. Doris Grinspun: Thank you so much. I actually hope to use as little time as possible and to have a dialogue as much as possible. It is a delight to be here with you today to discuss the Local Health System Integration Act.

Let me be clear: We support the LHINs, but the LHINs need some empowerment, and we will speak exactly about that.

The LHINs act led to the creation of 14 not-for-profit corporations called local health integration networks, which work with local health providers and community members to determine regional health services. They have a very broad mandate. However, in our view, the legislation, the act, actually doesn't enable them to do their work.

The LHINs currently cover hospitals, community care access centres, community support services, long-term care, mental health and addictions, and community health centres. That's about it. The LHINs do not cover, because of the act, the following services: home health care and support services, primary care organizations—except the community health centres—and public health units.

Much to our distress, on seeing the unfolding hampering of the LHINs' ability to actually enact what they are supposed to do, which is whole-system planning and whole-system integration, a year ago we decided to undertake significant work. In 2012, we released a report, which is in your files, entitled Enhancing Community Care for Ontarians, or ECCO, which we hope will have reverberations like an echo. ECCO proposes to position the LHINs as the overall health system planner at the regional level. However, for that to take place, we need to include in the act, directly, home health care and support services, primary care organizations—all of them—and public health.

Let me address a bit of what we can do and what the act should look like in the future if we are certain about having health system integration—and unnecessary duplication, which is costly to people, as expressed by our previous colleague in their description of the experience of Bernice, and also to taxpayers.

We are proposing that the CCACs evolve into moving the case managers that they currently have—3,500 of them—directly to work in primary care to actually support patients in the community, ensuring that people like Bernice don't suffer those experiences where an outside entity is supposed to come in a crisis situation to serve them, but it is actually the primary care system that is anchored in case management. Then, evolve the rest of the CCAC administration into the LHIN structure, thus enabling the LHINs to actually provide health system planning for all the services, including primary care, and including home health care.

We also propose that public health units need to be brought way, way more in line with the act and with the LHIN structure, again for two very important reasons. First of all—and here in Hamilton, it is so very apropos to say so—when you have communities that have not and communities that have much, that actually suffer 25 years

of longevity as a consequence—people here in Hamilton live 25 years less based simply on their income. Public health units' key mandate is to actually do health promotion, disease prevention, social determinants of health etc. The problem is that because public health units are not part of the LHINs now, we are again missing the boat.

We have LHINs, as a result of the act, that are primarily focused, I would suggest, on illness care and crisis care, and we are missing all the movement that the entire world—especially progressive countries and OECD countries that are doing things well—is doing with primary care, home care and public health. If we were to bring all of that under the act, the LHINs would finally be empowered to do what they were supposed to be doing in the first place, which is health system transformation, health system planning and health system funding that is fair across the province but localized in our regional communities.

I would strongly recommend, from the nurses' perspective, that we further empower the LHINs by bringing into the act home care services, support services, primary care organizations—not only the community health centres, but all of them—and also the public health units, and that together, then, we move into a model that is much more in tune with health promotion, disease prevention, chronic disease prevention and management, and, of course, also the area of mental health.

I would stop here, because I believe we can do, and must do, much better than the description we heard from our LHIN CEO on Bernice. Whether it was before or whether it is now, we still hear of too many Bernices across this province. In fact, when we released ECCO, we had people from the public contacting us, and we did a focus group with them to actually ask the public, “What will work best for you?” Many of these ideas in ECCO actually come from the experiences that the public shared with us.

Let me open for questions. My colleague Tim and myself will be happy to answer.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about nine minutes, so if we start with the government side—

Ms. Helena Jaczek: Thank you, Chair.

The Chair (Mr. Ernie Hardeman): Okay. Ms. Jaczek?

Ms. Helena Jaczek: Thank you so much, Doris, for, as usual, very specific recommendations. I guess I'll pick up on one that I have some knowledge of as a former medical officer of health, and that's your recommendation in terms of public health units. I guess there are a lot of barriers, and I'm sure you will acknowledge—I see in your presentation that you're suggesting maintaining the local governance model of a board of health, as well as responsibility to the LHIN, and I just see that as extremely problematic, having reported to the regional municipality of York for so many years. The fact that obviously municipal funding is part of—25% of public health funding comes from the municipality.

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Boundaries are a huge issue. Obviously, health units are based on existing municipal boundaries.

I understand where you're coming from in terms of health promotion and disease prevention, but I'm just wondering, in a practical sense, how you see this moving forward and if this dual reporting would be how you foresee that playing out.

Ms. Doris Grinspun: First of all, let me clarify, and my colleague may want to add. We are actually meaning that public health units need to maintain their own governance, no different than hospitals, no different than home care agencies and others, okay? We are not necessarily proposing that the dual reporting to municipalities etc.—we absolutely are saying that the system is missing out hugely. Let me be clear: At the time of the creation of the act and of the LHINs, and the conversations I had back then with my very close friend Sheila Basrur—I was totally on her same page. Let's keep the LHINs. Let's keep public health units out of it because—buga-boo: that was our fear, quite frankly, that hospitals will lead the budgets of everybody that gets in the picture.

I think if Sheila were here today, she would say, as we are saying, that that fear is gone. We are moving to more community transformation. We need to keep people healthy and well-served in their communities, in their homes, aging in place as much as possible. Therefore, we need to bring public health units to the next stage. We are also saying that public health units are supposed to be—many are; not all—the best entity, the best machinery, for community consultation, way better than hospitals, way better than home care etc. by the nature of them. The system, the LHINs and the act that doesn't allow the LHINs—it's missing out on not having that capacity of public health units to champion community consultation for everybody across the system. It's missing out on not forwarding social determinants of health and environmental determinants of health.

So we are saying they need to keep their budget—no different than the hospitals. They need to keep the ability to do also local programs—no different than the hospitals—but there needs to be a layer that is for the entire system as part of the LHINs.

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll now go to the opposition. Mrs. Elliott.

Mrs. Christine Elliott: Thank you. Hello, Doris and Tim. It's great to see you both again. Thank you for presenting to the committee and for your leadership in the production of ECCO. We have had the chance to discuss it several times, and I think there are some great themes in there. We have some disagreements on some parts of it, but I think it's a very solid document with some really good ideas.

I'm particularly interested in the idea of blending the function of the CCACs into the LHINs. We hear about it constantly in our community office, that the transitions are very, very difficult. It seems to me that if they're brought in to the existing LHIN system or there's some way of having them work together that provides seamless

service for patients and truly makes our system patient-focused—I'm wondering if you could just expand on that a little bit.

Ms. Doris Grinspun: We are absolutely, Christine, on the same page on this. First of all, just from the issue of whole system planning funding, it's impossible. If I were the colleague that spoke before—I don't know how you can plan if you actually do not have every player directly there.

Second, the LHINs are extremely lean in terms of their administration. The CCACs, on the other hand, we all know, are overblown in terms of administration. Our suggestion is that the case managers move to primary care where they will service the patients. The rest move to the LHINs or to home care services in terms of actually upping the ability of the LHINs to perform all-system planning. We do not believe that if you have these two overlaying structures—even though one reports to the other—the LHINs will be able to come to their full maturity. We absolutely do not believe that will be the case. They will continue to be hampered by another structure that is muddling in the middle.

The Chair (Mr. Ernie Hardeman): Thank you very much, and—

Ms. Doris Grinspun: We need one overall structure to do system planning, not two or three.

The Chair (Mr. Ernie Hardeman): Third party: Ms. Armstrong?

Ms. Teresa J. Armstrong: Yes, it's a pleasure to see you again, Doris, and it's nice to have you here today, Tim.

You touched upon unnecessary duplication within the LHINs, and I just thought if you could expand on some of those issues that you feel are unnecessary duplication that could help financially and also perhaps deliver services better to the health care system.

Ms. Doris Grinspun: Thank you. It builds on the previous question from Ms. Christine Elliott on the issue that there is duplication, first of all, between some of the functions of the LHINs and CCACs—that's the biggest one—and that that duplication is hampering the ability of the LHINs. And it's structural, because it's based on that. It's not that the LHINs decided; hence why the review of that is so timely and necessary. And it hampers both the ability to integrate and make services smooth, and also it hampers the ability because the dollars are used inappropriately. So that's absolutely the first layer of duplication; that is essential.

Ms. Teresa J. Armstrong: Any other duplication that you can identify that would help that overall delivery of health care?

Ms. Doris Grinspun: I would suggest that the fact that not all the primary care sectors are part of the LHIN create, just by structure, again, duplication sometimes. I mean, you have the CCAC supposedly to coordinate the care of Bernice, but actually, that's a role that belongs to primary care. Now the LHIN cannot mandate it because only community health centres—in fact, in community health centres, Bernice probably would not have experienced that. So that's proof in the pudding.

The third is in the area of public health. Hence why we're proposing that the three come to the act. In fact, you could also see during any of the epidemics—and if we have another one, we will see it again—when in some LHINs, you have several public health units actually giving different directions, at times, than the LHIN. So that's, again, a structural duplication in the way that they structure—that there cannot be a consistent and mandatory lining up of everything.

Ms. Teresa J. Armstrong: Okay. Perfect. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's very helpful, and I'm sure that we'll take it into consideration. Thank you for taking the time to come here.

Ms. Doris Grinspun: Thank you for having us again. Take care.

Mr. Tim Lenartowych: Thank you.

MR. HARRY CHUNG

The Chair (Mr. Ernie Hardeman): Our next delegation is Harry Chung. Thank you very much for coming and sharing your thoughts with us this morning. You will have 15 minutes to make your presentation. You can use any or all of it for your presentation. If time is left, we'll have questions from the committee to address your presentation. With that, thank you very much for being here, and the floor is yours.

Mr. Harry Chung: Thank you for having me. First of all, I'm a front-line health care innovator. I call myself that because I've been looking after my mum for the last six years. My previous careers: I'm an engineer; I'm a licensed security officer as well. I give you a little bit of my background, okay? I have a law degree as well.

I roughed this up last night because I was called to change my time, to come in at 11:45 instead of 1:15, so excuse the grammar or the spelling. I did the best I could.

For the last six years, ever since my mum got out of hospital, I was in a situation where a social worker came to my family without us having an idea of what was going on with our mother. She had a heart attack back then. I just gave up my career and went straight to the hospital and spent 18 hours a day, 40 days there in the hospital, just to make sure everything was running good for her.

Being a lady from a different culture, a Chinese Canadian—I've been here for four generations, my family, in the city of Hamilton. We never had a voice or anything. I think it's time we speak up. The culture for health care given to the public back then was good for people of European cultures, but for the Chinese Canadians—I mean, my mother doesn't eat hamburgers and French fries and mashed potatoes and stuff like that. She likes her culture's food, which is basically Chinese Canadian food. What I'm trying to do is suggest a way to improve our system.

The thing is, our system in a hospital is—it's the way they approach the families. You know, you get the family all split up. There's no cohesiveness and there's no

family unity there after you go through the round table meeting with the social worker in the hospital. Everybody has got different ideas of what's good for our mother, or any elderly people like my mother.

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There's no sense of security in nursing homes, as you can see on these handouts I have passed around. These are all newspaper clippings from the last six years. Before that, there wasn't that much security in nursing homes either, but these are just clippings from within the last six years. I've been collecting these.

Also, there's no sense of security with the PSWs, the in-home-care service. Mind you, the PSWs are great health care workers, but there are some who are kind of shady; I'll just use those words. As you can see on the first page of this, we've got PSWs coming into the house and stealing \$57,000 from an elderly gentleman. There's no sense of security, safety, or trust, I guess I'd call it, in the system. But having what we have on hand—you have the home care system and you have the nursing care system—we have to find ways to improve the sense of security in these homes.

I've written some ideas on how to improve what we've got. The system can work if we have a sense of security in the system. My suggestion is that if you're going to have a nursing home, before you should even have a nursing home—a building labelled as a nursing home—to provide health care services, I believe you should have a security system in place. Maybe have specially trained security guards who work in the health care facilities. Without that, it's just a building with a bunch of nurses there. I'm pretty sure the nurses are doing their jobs, but still, there's no security there.

The security staff that they hire: There should be at least three, I would suggest—at least three security guards—with special health care training, just enough so that in case somebody falls or hurts themselves, they are there for the moment until a nurse or PSW comes to take care of the major issue.

These security guards are not just ordinary security guards. I believe they should be trained a little bit, rather than just CPR and St. John Ambulance first aid training. Also, the security system in the nursing homes should be more arm's-length. They should work in tandem with the nurses, the doctors, the caregivers, but at the same time they've got to be at arm's length. Their bosses should be somebody else rather than the nursing home owner.

That's how I would suggest improving the nursing homes in our system.

On the other hand, we have health care providers coming to our house, looking after our elderly. You see, it took me six years to become very friendly with these PSWs coming to my mom's house. I couldn't trust them at the beginning, to be honest with you. I don't know who they are. It took six years for me to be able to say, "Okay, I'm going to go out and have a coffee at Tim Hortons, so that these ladies can take care of my mom." But, seriously, it took six years to build that security and trust. That's six years of my life I gave up, as an aerospace engineer, to do this.

Now, the thing is—I always suggested this: In their house, you should find out how many siblings or how many kids the elderly parent has. If you have none, that's a different story, but it's also suggested in here how we can go ahead and fix that too.

You should have at least one show of a family member in the house. That family member—they're there, right? They can be watching TV or sleeping in the next room or on the computer or gardening, or just going for two minutes to Tim Hortons and back. I don't think they should leave the elderly at home by themselves.

When you have a PSW come to your house or a health caregiver come to your house, even if they're so friendly and nice, you still need that interpretation. All the health caregivers I have come to my house speak Spanish, Ethiopian, East Indian, but my mom's Chinese Canadian. She doesn't speak a word of good English. By the way, for that one reason, they should also have a family member in the house. I know we can say, "I'm too busy doing this, I'm too busy doing that," but the thing is, it should be mandatory. They should find out how many siblings or kids the elderly parent has. As an example, if they have four kids, maybe three daughters and a son, take the 24-hour clock and divide it by four—four members. Or if they have grandkids who are over 18 years old, count them in as well.

But just say, for example, you've got an immediate family member and maybe four kids. Take the 24-hour clock; divide it by four. That's six hours each. Six hours each a day is not much. If you're at home cooking a meal, you could be cooking a meal at your mother's house and make her a meal, too. The PSW comes. There's a sense of security there for my daughter, my son. But we're not asking them to do all the caregiving, because they can get tired doing that every day. But just be there. Have a show that they're at home. This is called family unity.

At the same time, the caregiver and the person at home can work in tandem. If they need a little bit of help, call 911, or if something happens to the PSW. At the same time, that extra person at home can provide a little bit of help. This is where I'm coming from, in terms of sense of security and safety in the house.

The reason why I mention this is, because also in the newspaper here, there are people going into people's houses; for example, the first one. The first example here, you've got a PSW coming in here. I'm pretty sure she has good intentions of taking care of the old man right there, but the thing is, though, you've got a blank cheque that's laying around, and you can write any price you want. So you've got two PSWs at court this month. We don't know what the outcome is.

There's various other cases. It's all here. You've got the elderly at home by themselves. They fall and hurt themselves, and nobody knows about it. Then you've got examples in the hospitals, where some of the health care providers in the hospitals and the nursing homes—they are basically neglected. You've got examples where you've got an elderly lady letting—mice, rats eating the

corner of their eyes. They're alive. There are instances like that in these newspaper clippings here.

You've got an instance where you got a nurse who burnt down a nursing home with about 87 patients who have dementia, and five didn't make it. There's various situations like this. It's all here, for the last six years—all here.

This is my suggestion. This is what I suggest to help improve our system. We have a system, but it's just a matter of improving it. You have a choice: nursing home or a caregiver coming to the house. But they should be looked upon as equal.

Also, the kids who are asked to be at home show us a sense of security for the elderly, this should be a mandatory thing. If you have four kids or five kids and maybe three grandkids who are over 18, and you're still in the Hamilton area, you should get these people to work out a schedule and make it mandatory. They have to do their hours. It's their parents we're talking about. They may have differences, but still, it should be a mandatory thing.

We're not asking these people, like myself, to actually do a lot of health care work but just to be around. You don't want to leave an elderly 87-year-old in a house by themselves with strangers walking in. These health caregivers—they may have good intentions. But, then again, who knows? They're strangers. They're strangers to the 87-year-old elderly. You don't want to make them feel like they're in a house with a strange person.

I know one can say, "Well, we don't have enough people to come to the house. Why don't you throw them in a nursing home?" You should look at the situation. Can this person survive in a nursing home? I don't think my mother could survive in a nursing home; she'd probably die in two weeks. But here she's living still: dementia, 87 years old. We cope with it, find a way around it. That's the idea of taking the siblings, divide it by a 24-hour clock so that we're not always there for 24 hours listening to your mother when she's in dementia mode. So that takes a load off of a lot of people. Then you've got the PSWs coming in to give that extra measure of help.

So this is how I think we can improve our system. We got a system there. It's just a matter of improving it.

Any questions from anybody?

The Chair (Mr. Ernie Hardeman): Okay. Well, we have a few minutes left. I have about a minute and half for each caucus. We'll start with the official opposition.

Mrs. Christine Elliott: I'd just like to thank you very much, Mr. Chung, for coming and appearing before the committee today and raising some of the significant issues around frail, elderly patients and their caregivers, and the need to make sure that there are choices whether they go into a long-term-care facility or whether they choose to remain in their own home. I think, for the most part, that's where people want to be. It's also more efficient for our health care system, so we need to make sure that we have a robust system that allows people to have those choices. So thank you very much for bringing this forward today for us.

Mr. Harry Chung: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. The third party? Ms. Armstrong?

Ms. Teresa J. Armstrong: Yes. I want to thank you, Mr. Chung, for sharing your experiences that you are going through right now. I got a sense that you obviously feel very committed to your mother, and how important family is to you, looking after your mother when she is in this situation.

You also raised a theme about security and trust when people enter your home. A lot of people do have those issues, but perhaps I'd encourage you to call your local CCAC and find out what their processes are, in order to maybe substantiate some of those security and trust issues you may have. I'm sure there are systems in place that help that situation.

Congratulations on trying to find that balance there, and having them come into your home, and having your family also participate. Thank you.

Mr. Harry Chung: I do talk to my local CCAC—for the last six years—but it's just coming to your house, sitting at a laptop and asking what kind of medicine your mom takes. I'm very well aware of that.

Ms. Teresa J. Armstrong: That's good.

Mr. Harry Chung: Nothing is happening. I'm taking advantage of this meeting to make it happen. I'm a practical person, a technical person. I'm not a politician. I have a law degree. I'm an engineer, but I consider myself a health care innovator. I believe in making it happen, making it work.

Ms. Teresa J. Armstrong: No, your contributions were—

Mr. Harry Chung: This is my experience sharing it with somebody who has never had it for six years. I'm still doing it, so I'm learning a lot. I'm bringing my front-line experiences onto the table. That's what I'm talking about.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. We'll go to the government. Mr. Colle?

Mr. Mike Colle: Yes. Thank you, Mr. Chung. Obviously, you care a great deal about your 87-year-old mother, that you're coming here on her behalf—and other mothers like her—so I want to commend you for that.

I think you make a very good point: We can't just keep serving people hamburgers and chips in the hospitals. I know that one of the complaints I get the most is the food. It's just the same old hamburgers and chips. Meanwhile, we've got such a diverse province with people from all different backgrounds. We need to take more attention to look at the cultural background, the family background, especially of our elderly, to make them feel comfortable when they're in a nursing home or a hospital. I think you've made an excellent point that we've got to pay attention to and all the providers have got to pay attention to. We just can't do the hamburgers and chips forever.

Mr. Harry Chung: That's right.

Mr. Mike Colle: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That does conclude the 15

minutes, so we thank you very much for coming in. We do wish you well.

Mr. Harry Chung: Thank you for having me, everybody.

The Chair (Mr. Ernie Hardeman): Thank you.

We now have a recess for lunch. That's the end of it for this morning. Lunch is in the Charlton Room. We shall see you there.

The committee recessed from 1154 to 1300.

COMMUNIST PARTY OF CANADA (ONTARIO)

The Chair (Mr. Ernie Hardeman): We'll reconvene the committee. Our first presenter is Elizabeth Rowley from the Communist Party of Ontario. Bob Mann is also here with her. Please come forward and take a seat at the table. You have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If you do not use it all and there is less than four minutes left over, we will give that to one caucus to ask questions; and if there's more than four minutes left over, we'll divide it equally among the three parties. With that, the floor is yours. Thank you very much for being here.

Ms. Elizabeth Rowley: Thank you very much. Good afternoon, ladies and gentlemen, brothers and sisters. My name is Elizabeth Rowley. I am a former public school trustee and member of the board of health and currently the leader of the Communist Party of Canada (Ontario). With me is Bob Mann, who is a member of the Communist Party's Ontario committee and also a retiree from Stelco, down the road.

Perhaps we'll just go straight to the brief that we want to submit and begin by thanking you for this opportunity to address you on the review of Ontario's local health integration networks and the legislation.

When the LHINs were first created in 2006 by legislation, we noted that their main purpose would be to serve as a buffer between the government and the public. Eight years later, it's clear that the real purpose of this legislation was to redirect public anger away from the government, which had continued implementing most of the privatization policies introduced by the Harris government, including those the Liberals had campaigned against in 2003 and, in particular, P3 hospitals, cuts to hospital and health care spending, new and higher user fees and privatization of health care services. This government also extended balanced budget legislation to hospitals, in the process extending the Harris' government's create-a-crisis policy in education to health care.

According to the Canadian Institute for Health Information, public health care spending in Ontario dropped to \$3,963 per capita in 2012, compared to Alberta at \$4,896 per capita and Newfoundland at \$5,399 per capita. From a leader in health care in Canada, Ontario now ranks eighth out of 10 provinces. Compared to the average per capita spending on health care across the provinces, Ontario spends \$8.6 billion less on health care.

Ontario ranks dead last in the country on hospital spending, with per capita spending in 2012 at \$1,372.

Alberta, which was ranked second, spent \$2,194 per capita in the same year. Compared to the average per capita hospital spending across the provinces, Ontario spent \$6.7 billion less on its hospitals. Further, in the past 30 years, spending on hospitals has been cut by almost 50% as a percentage of all public health care spending.

As a percentage of the provincial GDP, Ontario's health care spending has dropped to 8.07%, again ranking Ontario eighth out of 10 provinces. As a share of provincial spending on all social programs, spending on health care in Ontario has dropped from 47% in 2012 to 42% today. Ontario has the dubious distinction of ranking last in all social program spending across the provinces.

Further, in last year's budget, the government introduced means testing for seniors' drug benefits. User fees are expanding and increasing as the government continues to de-list services and procedures.

What will the picture be two years from now if this austerity plan continues? Indeed, as these figures show, a health care crisis has been created as a result of deliberate cuts to the funding of health care and hospitals in Ontario. It's this made-in-Queen's-Park crisis that the LHINs are expected to mitigate and to answer to an increasingly angry public.

As expected of an agency created by, appointed by and accountable to the government of Ontario, the LHINs have become an important instrument of privatization.

Again, according to the Canadian Institute for Health Information, Ontario has the highest percentage of private health care spending in Canada. Fully 32.3% of all public health care spending in the province is spent on private health care. Even Alberta, the ideological home of privatization and deregulation, spends less at 27.1%.

Private health spending is 5.3% higher in Ontario than in Canada as a whole. Private health care administration costs an astronomical 6.4% of public health care spending, while public administration costs just 1.8%. Part of this is due to the absence of regulations over private and private for-profit health care facilities in Ontario.

According to the 2008 Auditor General's report, P3 hospitals have cost hundreds of millions of dollars more than publicly procured hospitals. In the case of the Brampton P3 hospital, Ontario's Auditor General calculated a \$194-million difference in building costs and a \$64-million additional cost in renovations for the P3 over public procurement. This included a whopping 13% cost overrun, almost three times the amount permitted in public procurement contracts. This P3 hospital generated a very tidy profit for the for-profit partners in this P3, while the public organized bake sales to pay for it. Furthermore, the hospital was smaller, with fewer beds and staff, than the public hospitals it replaced.

While the government continues to chip away at universal health care and the Canada Health Act, it is today moving to speed up privatization by enabling and directing the LHINs to eliminate many hospital services and contract them out to private and for-profit clinics, known as independent health facilities, IHFs. There were

825 of these in 2012, 97% of them for-profit clinics, according to the Auditor General in his 2012 report.

Contracting out hospital services is not intended and will not free up hospital beds or alleviate long wait times for emergency care or surgeries. In fact, many of the IHFs are expected to provide surgery as part of their mandate. Already existing private clinics have been the subject of sharp criticism and demands that the government act to stop them from demanding fees for service and other illegal charges from patients while also charging OHIP. Furthermore, medical oversight and regulation is de facto absent over most private clinics today. The death of Krista Stryland is an example. It will be completely absent if the Conservatives form a government and carry through with their promise to eliminate red tape—regulation, in other words.

As hospital services shrink and decline with the introduction of IHFs, so too will hospital funding, along with hospital beds and wards. Small hospitals could be pulled apart as services are pieced out. As already noted, the Brampton P3 provides fewer beds to a larger and growing population than its two public predecessors, so much so that at least one person has died in the waiting room of Osler's emergency department.

Rural hospitals, which are generally smaller, and services to rural residents, who live in a larger geographic area than their urban counterparts, are most immediately in danger because of their size—or at least they are first in line—with the introduction of IHFs, privatization by any other name.

If the government wants to decentralize public hospital services, it can do it under the Public Hospitals Act by creating publicly owned and operated clinics, either stand-alone or connected to particular hospitals. The government's apparent decision not to do this and to contract out these services to private and for-profit clinics is very telling.

By making the LHINs the agency that actually cuts and privatizes these important health services, the government expects public anger to focus on the local LHINs and not on the minister or cabinet. It is a cynical policy, indeed, and one that contributes greatly to widespread public cynicism about parliamentary democracy, transparency and accountability.

Ontarians want hospitals and health care that measures up to the standards in the Canada Health Act and exceeds them when it comes to pharmacare, long-term care, vision and dental care, and mental health care. Instead of colluding to destroy medicare, the provincial and federal governments must invest in public health care and hospitals, as well as in public education and universal social programs that benefit all Canadians. User fees should be outlawed.

Recovering the estimated \$15 billion in corporate tax cuts and significantly raising corporate tax rates, now the lowest in the industrialized world, according to budget papers, would generate the funds needed to pay for universal health care services while creating jobs in health care and improving the health and well-being of

all Canadians. Canada is a wealthy country, and Ontario is a wealthy province. Progressive taxation based on ability to pay would ensure that the public purse was up to the task. What is missing is a government up to the task.

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The Ontario and federal governments, current and future, should be guided by the principle that health care is a right, not a privilege. In this scenario, there is no room for IHFs or LHINs, which should be abolished along with private, for-profit medicine and the private clinics and health care corporations that are the barbarians at the gates today.

The LHINs should be replaced by boards of health that are publicly elected and accountable, and that in fact place “significant decision-making power at the community level and focuses the local health system on the community's needs,” as stated on the Ministry of Health website.

In conclusion, the first plan for socialized medicine in Canada, laid out in the 1930s by Dr. Norman Bethune, laid the basis for the successful fight for universal medicare that involved millions of Canadians from coast to coast in the post-war period, and the courage of Tommy Douglas and the CCF government in Saskatchewan to bring it to life. Medicare was no gift to Canadians. It was the fruit of a historic struggle by working people—labour, farmers, women, youth, seniors, professionals, aboriginal peoples and migrants—to win universal, quality, public health care as a fundamental right for all. Governments of all stripes were finally forced to put people's needs ahead of corporate profits—a victory that corporations and governments have been working hard to undo ever since.

Canadians will not stand by while medicare is privatized, by stealth or otherwise, as polls consistently show. The Legislature would do well to take note.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We'll start the questions with the—

Interjection.

The Chair (Mr. Ernie Hardeman): Okay, it's just one party. There are just 2.46 minutes left. We'll have questions from the third party. Ms. Taylor?

Miss Monique Taylor: Thank you for being here today. Thank you for your presentation and for putting the effort in to come to speak to this very important issue regarding the LHINs.

I don't really have any questions of you. You definitely put together a very pointed presentation with a lot of—actually, I do. Where did you get a lot of your facts and figures from—the numbers?

Ms. Elizabeth Rowley: As you will see, it says in the brief that most of the figures come from the Canadian Institute for Health Information.

Miss Monique Taylor: They were good numbers, and they were a little different from what we've been seeing, so I was happy to see those numbers come forward.

Thanks for bringing to light the fact that Tommy Douglas was the first person to bring forward health care and make sure that we had that legislation in place. Health care is definitely not a privilege; it's a right.

Ms. Elizabeth Rowley: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

The last presentation was cancelled, so that concludes our meeting for today.

Is there anything else that anyone wishes to bring up? If not, I just wanted to remind the committee that tomorrow morning, the meetings start at 8 o'clock as opposed to 9. So if we could all be in Kitchener-Waterloo at 8 o'clock, that would be much appreciated.

With that, the meeting is adjourned till tomorrow morning at 8 o'clock in Kitchener-Waterloo.

The committee adjourned at 1316.

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